

"Serving Our Communities with a Commitment to Excellence."

May 2007



Warren County Health Services is governed by the Board of Supervisors who are the legislative body for the county.

The Board of Supervisors is charged with:

- ✦ *Appointing a Director of Public Health and Early Intervention Official and a Director of Home Care*
- ✦ *Providing for proper control of all assets and funds and adopting the agency's budget and annual audits*
- ✦ *Entering into contracts with individuals and/or facilities to allow for services or reimbursement mechanisms*
- ✦ *Ensuring compliance with all applicable federal, state, and local statutes, rules and regulations*

Health Services Committee

A subcommittee of Supervisors that advises the full Board of Supervisors

- **John Haskell, Thurman**
- **Michael Barody, Queensbury**
- **Fred Champagne, Queensbury**
- **Richard Mason, Glens Falls**
- **Louis Tessier, Lake George**
- **Joseph Sheehan, Chairman Glens Falls**
- **Frank Thomas, Stony Creek**



2006 Annual Report

Purpose of Report

- Provide an opportunity for annual review and evaluation of various Health Services Programs by Board of Supervisors
- Provide a public record of accountability
- Serve as a resource document

Who We Are

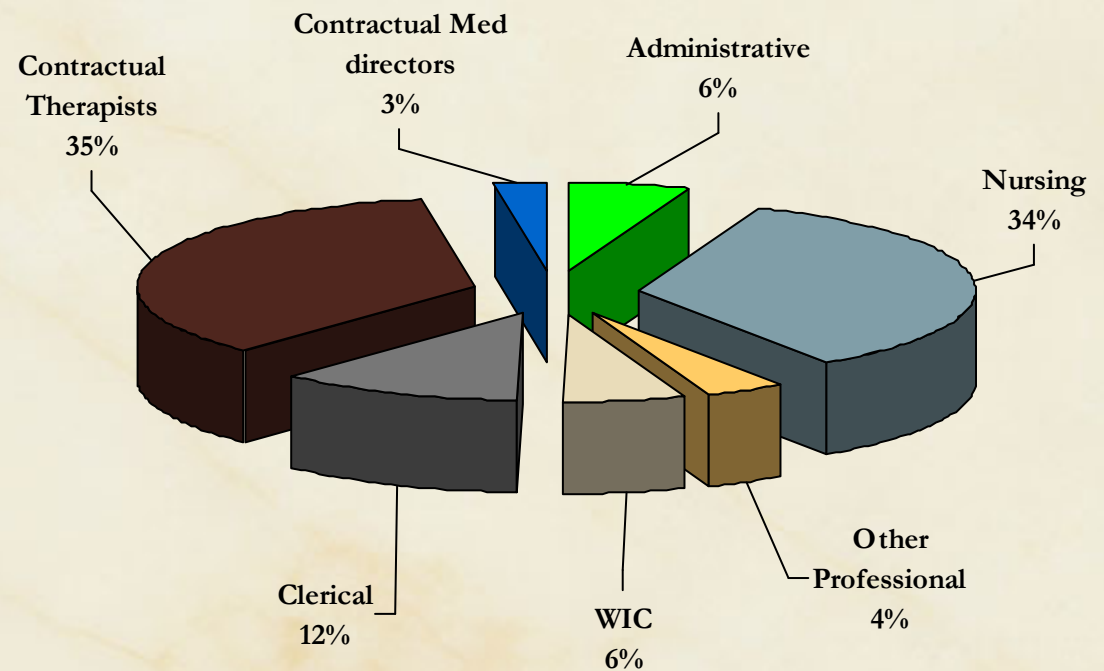
Health Services Consists of:


☺ 68 Full Time Staff

☺ 16 Part Time Staff

☺ 12 Per Diem

☺ 59 Contractual





Warren County remains fortunate to have the expertise of our staff. The quality of our Health is a direct reflection of continual commitment, dedication, care and knowledge coupled with the excellent team efforts of the following individuals:

Marietta Anderson

Robin Andre

Jeannette Arends

Shauna Baker

Jackie Barney

Julie Bauer

Cheryl Belcher

Patricia Belden

Barbara Bennett

Heather Benson

Craig Briggs

Rechelle Bullard

Debbie Burke

Gloria Burnham

Sandra Bublitz

Linda Bush

Gwen Cameron

Francine Chase

Cheryl Fuller

Nancy Gasper

Nancy Getz

Mary Lee Godfrey

Dana Hall

Kathy Harriss

Patricia Hart

Meg Haskell

Michelle Hayward

Anne Horwitz

Glenda Johnson

Ginelle Jones

Elaine Kane

Barbara Karge

Cathy Keenan

Michelle Keller

Sue Kerr

Heidi Knickerbocker

Dorothy Muessig

Mary Murphy

Patty Myhrberg

Barbara Orton

Diane Pfeil

Nancy Pieper

Patricia Porta

Helen Powers

Stella Racicot

Kelly Richmond

Lynne Rodriguez

Nancy Rozelle

Leslie Russell

Laura Saffer

Jean Saltsman

Grace Saville

Lisa Saville

Susan Schaefer



Shannon Clarke
Tara Cote
Beth Coughlin
Dawn Decesare
Diane Decesare
Tammie DeLorenzo
Jessica Depalo
Tawn Driscoll
Cathy Dufour
Dan Durkee
Karen Fidd
Rita Flynn
Judy Fortini
Nedra Frasier
Diane Fredrick

Nancy LaFrance
Mary Lamkins
Laura Lane
John Lemery
Ramona Leonard
Maureen Linehan
Amber Lynch
Jo Marie
Lisa Marlow
Kathy McGowin
Angela Meade
Kate Meath
Jackie Merritt
Barbara Moehringer
Joann Morton
Lisa Morton

Sharon Schaldone
Patty Skrynecki
Linda Slattery
Joyce Smith
Melody smith
Jean Spencer
Helen Stern
Shannon Stockwell
Patricia Tedesco
Linda Walker
Sandy Watson
Valerie Whisenant
Diedre Winslow
Donna Wood
Jeanne Wood
Marilyn Wood

I am honored to be their colleague ~ *Pat Auer*



Support Staff - HC



Fiscal Team



Communicable
Disease
Nurse



Support Staff - PH



Health Education

Thank You Volunteers



*Thank You From All Health Services.
We Couldn't Do It Without You!*



Who We Serve

Warren County Demographics

Population Estimate for 2005 – 65,548 (+2.9%)

Population Diversity (2000) – 97.5% White
(all other races less than 1%)

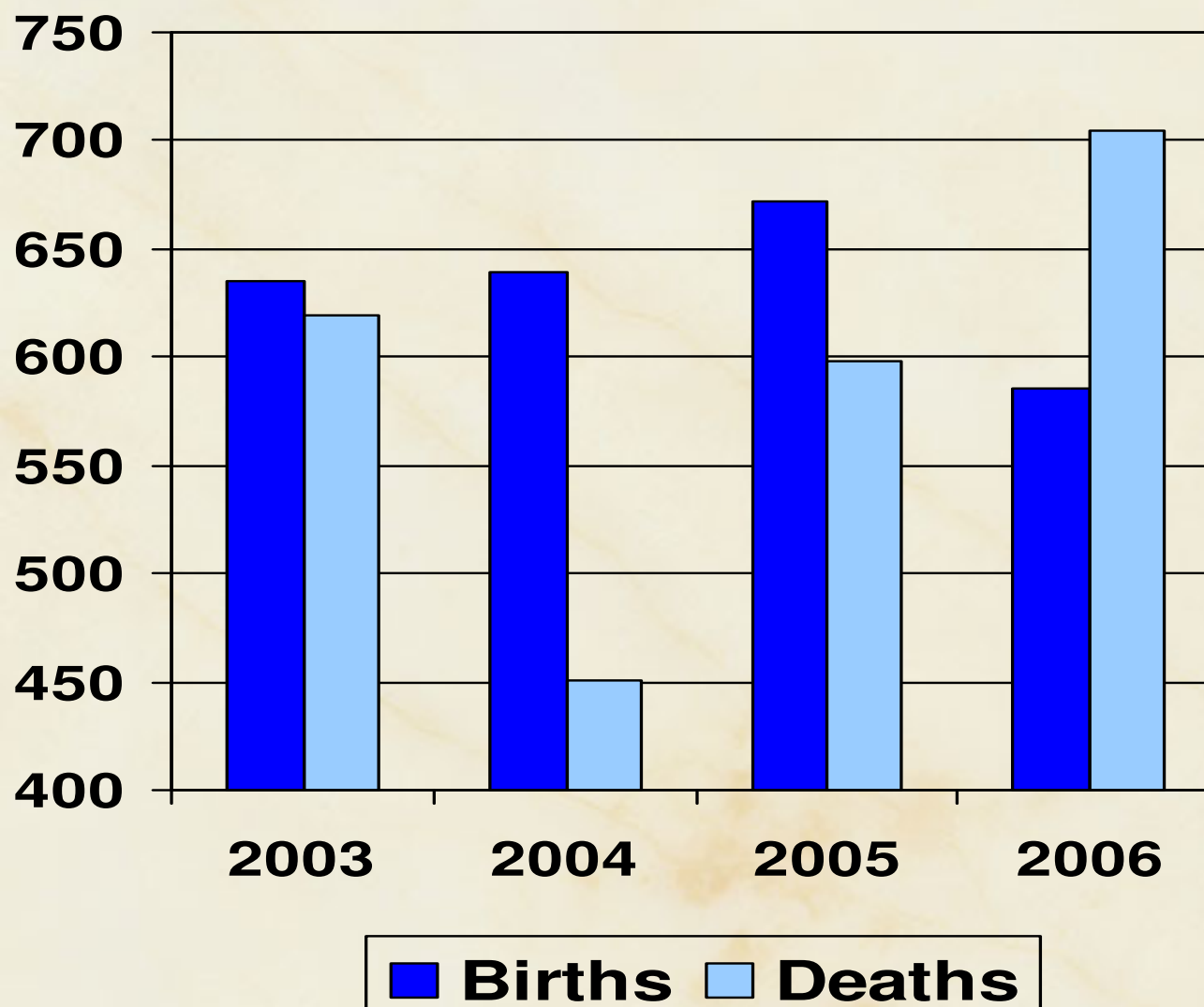
Percent of High School Grads. 25+ (2000) – 84.6%
(higher than NYS average 79.1%)

Persons Below Poverty Threshold (1999) - 10%

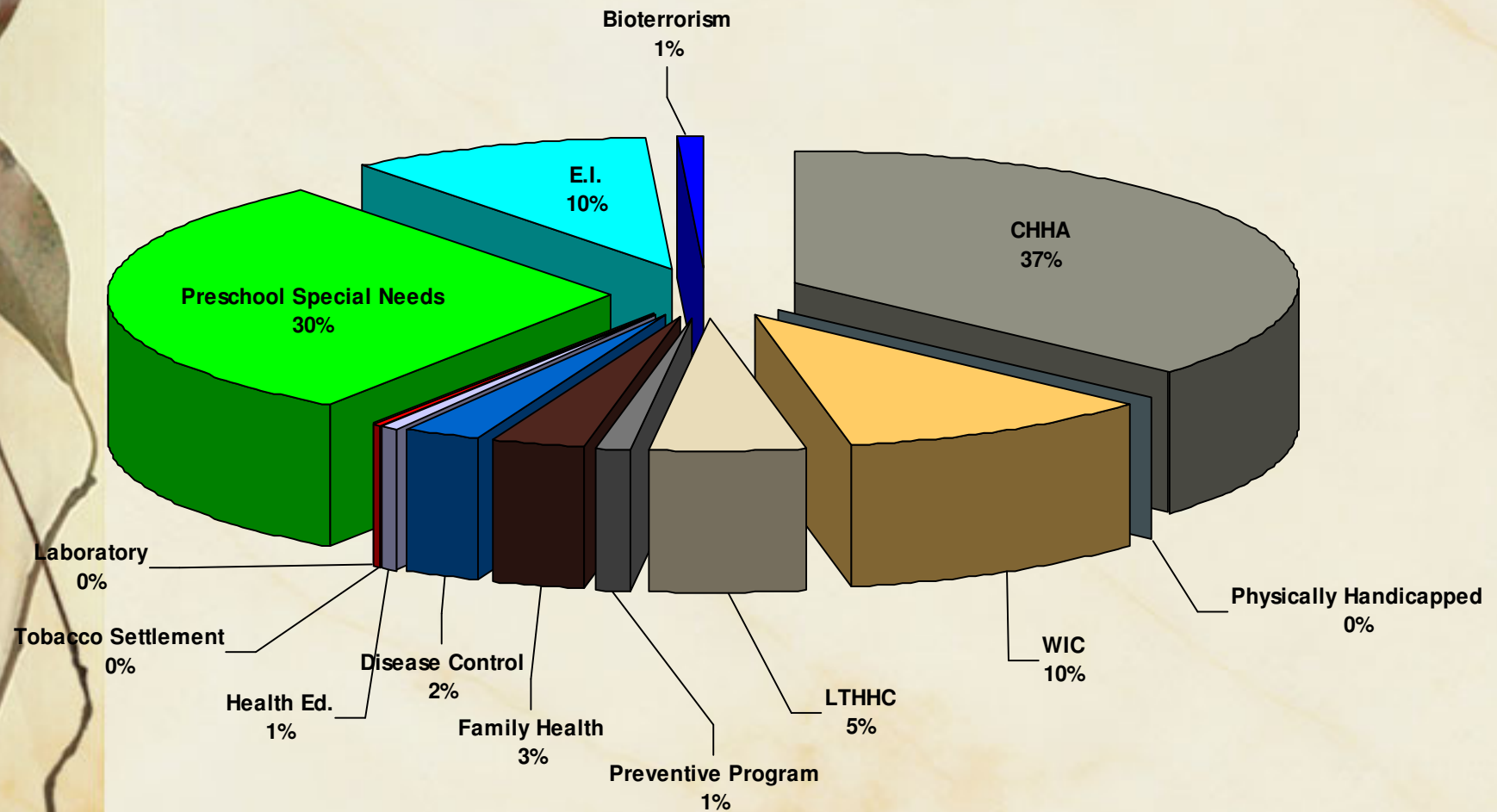
Land Area – 869 sq. miles

*For more information go to U.S. Census Bureau: State and County Quick Facts, <http://quickfacts.census.gov/qfd/states/36/36113/html>

Births and Deaths



2006 Expenditures By Program



Total Expenditures: \$11,542,209



Division of Home Care

Caring for the Community

“There’s No Place Like Home”







Home Care Services Goals

- ✓ Instruct and support the patient and family in self-care and disease management through the use of skilled nursing services, therapies, medical social services, nutritional, home health aide services and telemedicine.
- ✓ Provide health guidance to all ages to help individuals, families and the community achieve and maintain optimum health.
- ✓ Participate in ongoing assessment of the community's health, social needs, and resources to affect appropriate program planning.
- ✓ Develop, implement and maintain a cased managed program for persons who stay at home rather than enter a nursing facility. This is the Long Term Home Health Care Program



Quality Improvement Program

Program is designed to improve & enhance client outcomes through monitoring.

Accomplishments

- Steering Comm. developed disease management protocols for CHF/COPD. Telemed patients are instructed on the protocols upon admission into telemed. Provides knowledge to patient/caregivers for better disease management.
- Home Health Culture Survey conducted 4/06. Addressed basic processes and infrastructure that impact the ability to adapt, implement, and sustain best practices. Staff (all levels) were surveyed. Results: above average. A Plan of Action was developed to address agency communication at all levels.



Q.I Continued

- Chart Committee met monthly to review all patients w/ CHF/COPD. Results indicated all CHF/COPD patients received disease management instruction. 90% received telemonitors.

Established Plan's of Action

- Improvement in Management of Oral Meds. (+3.3% from '05)
 - Improvement in Dyspnea (+4.3% from '05, 8.7% above nat. ave.)
 - Improvement in Pain Interfering w/ Activity (+1.3% from '05)
 - Decreasing Acute Care Hospitalizations
-
- Wound Advisory Board met monthly. Reviewed high utilization/cost cases. Used to ensure best care, efficiency, and cost effectiveness while improve wound status. Surgical wound number improvement: 26% higher than nat. ave. Surgical wound status improvement 3.0% higher than nat ave.

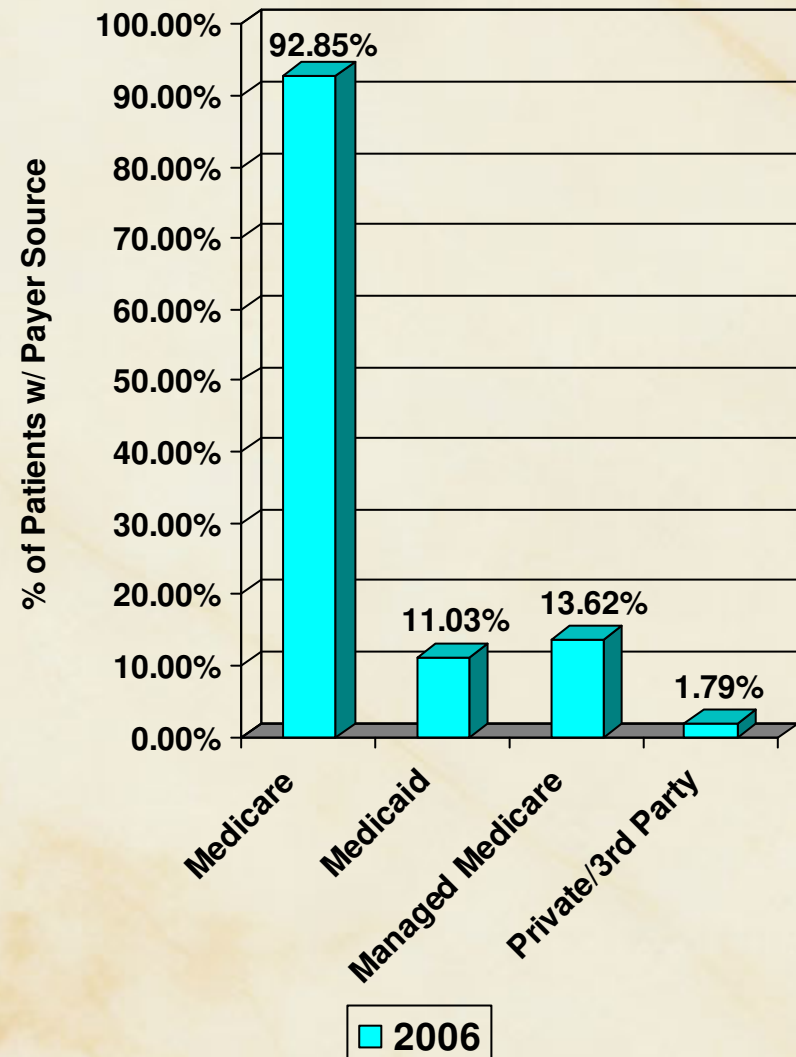


Q.I. Continued

- Utilization review Overview: reviewed 72 records: 66 cases had adequate utilization only 3 had underutilization. Cases were isolated and case managers were counseled individually. Active patients on last day of '06, 768 (+21) from '05

Patient Profile

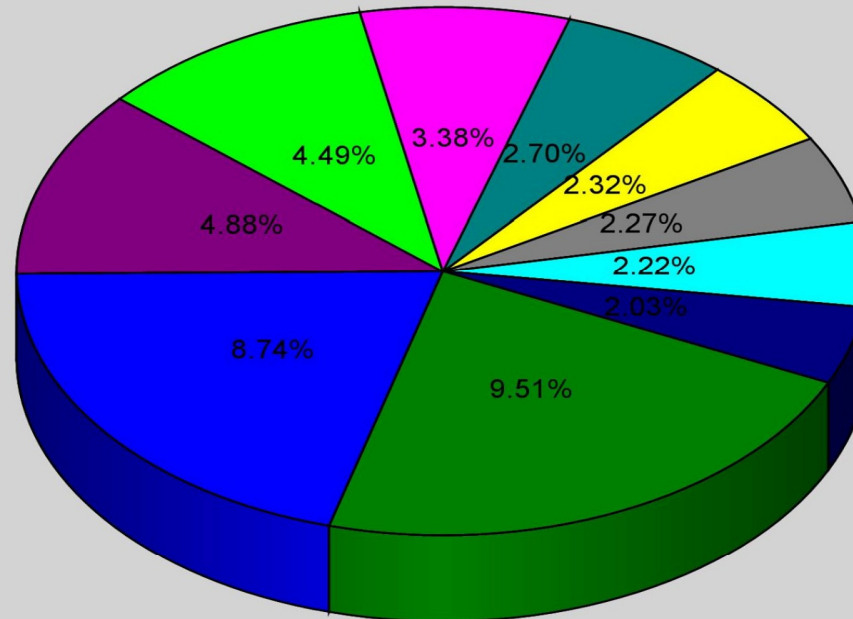
- Average age – 76.21
- Majority of patients are female – 60.54%
- Fifty-seven percent of patients live w/ family.
- 68% were admitted to a hospital prior to admission into county program (higher than national average).
- 36.81 days – Average length of stay slightly lower than national average.



Top 10 Primary Diagnosis

For Visits Between 1/1/2006 and 12/31/2006

For CHHA & Long Term Care Programs



- V54.81 - Aftercare following joint replacement : TOTAL CASES = 197
- V57.1 - Physical therapy NEC : TOTAL CASES = 181
- V58.73 - Aftercare of circulatory surgery : TOTAL CASES = 101
- 428.0 - Congestive heart failure : TOTAL CASES = 93
- 491.21 - Obs chr brnc w act exa : TOTAL CASES = 70
- V58.81 - Fit/adj vascular cathetr : TOTAL CASES = 56
- V58.75 - Aftercare following GI surgery: TOTAL CASES = 48
- 715.90 - Osteoarthritis NOS-unspec : TOTAL CASES = 47
- V58.42 - Aftercare of CA surgery : TOTAL CASES = 46
- V58.77 - Aftercare of skin and subcutaneous tissue : TOTAL CASES = 42

Telemed Program 2006 Eval.

2006 Accomplishments

Served 191 patients (unduplicated) double the patients projected. Medicaid was primary payer for 18% of patients (surpassed goal of 17%).

Reduced nursing visits per episode by 50% in CHHA (surpassed goal). LTC saw no decrease in visits (only averaged 2 visits a month at start of program). However patient compliance increased as evident by a decrease in hosp.

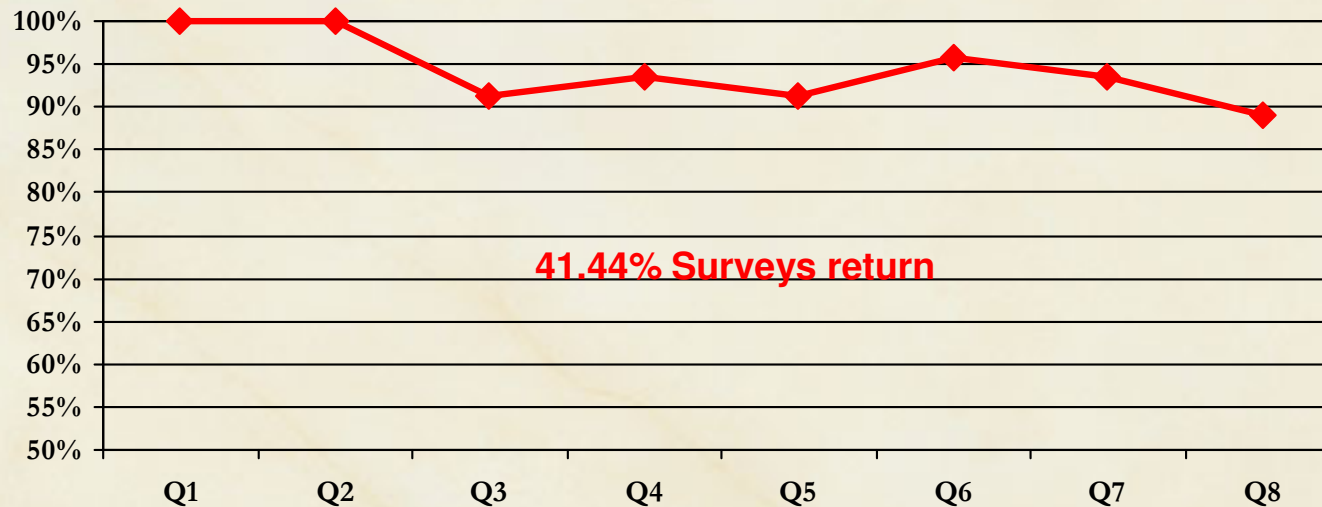
Hospitalizations decrease from 40% to 12% (12 mth. per.) for CHF and COPD. LTC had a 68% decrease in hosp. and had 3 patients w/ no hosp. (22 total patients)



Above: A nurse helps a client with the new Telemed equipment.

Below: An elderly couple happy about being able to stay at home, thanks to the new Telemed equipment.

Telemed Patient Satisfaction Survey



Q1: I think I was well educated on the use of the monitoring system

Q2: The monitoring system is easy to use

Q3: The monitoring system is useful in assisting me to manage my health

Q4: I felt more involved in my care by participating in the monitoring program

Q5: Daily monitoring enhanced the care I received from my home care agency and my physician

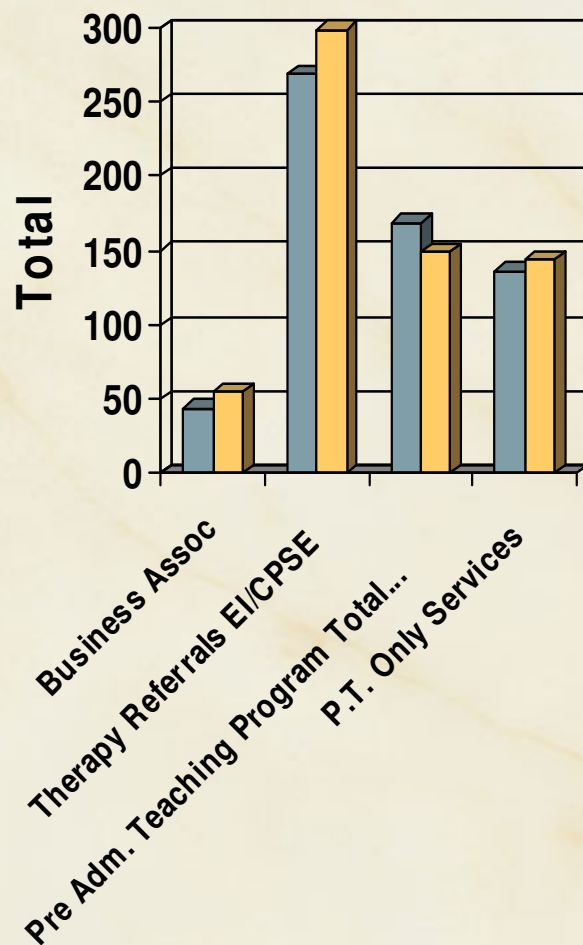
Q6: Home monitoring provided me with a sense of security and peace of mind

Q7: I would use the monitoring system in the future

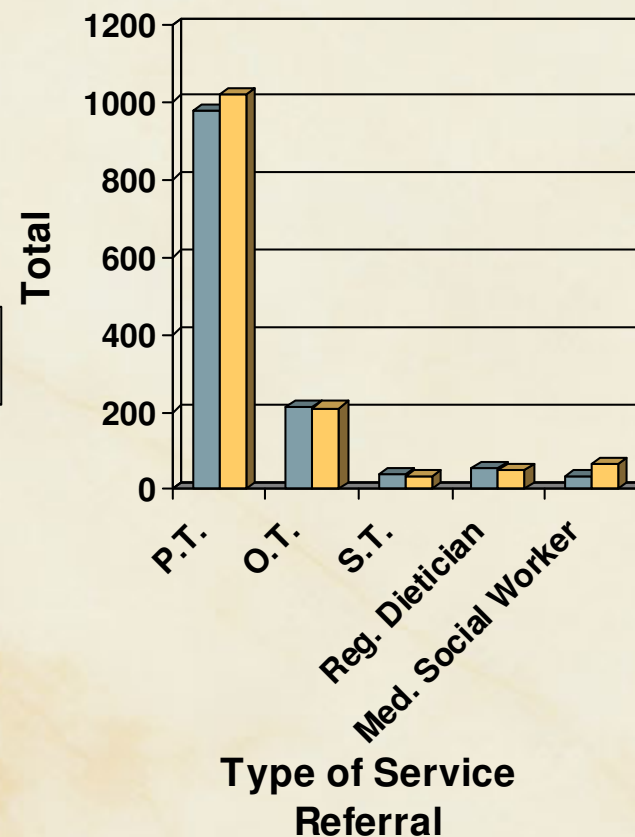
Q8: I would recommend the home monitoring system to my family and friends

Therapy Services

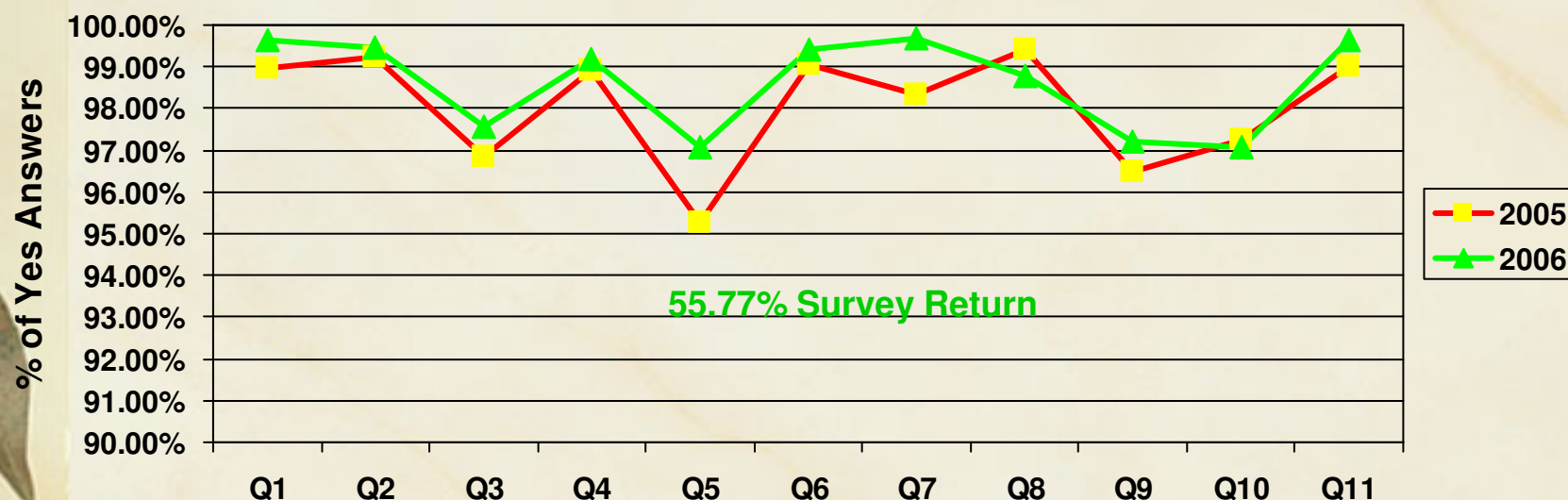
Of Referrals



Services



Patient Satisfaction – CHHA 2006



- Q1 When health nurse or therapist visited your home, did you know why she/he was there?
- Q2 did you and the nurse or therapist arrange a time for the visit which was convenient to both of you?
- Q3 Did the nurse help you understand what your medication was expected to do for you, and any side effects to watch for and report?
- Q4 Did the nurse examine you when she made a visit (i.e. take your blood pressure, pulse, listen to your chest w/ stethoscope, weigh you, take your temperature)?
- Q5 Did the nurse/therapist teach you the possible complications related to your illness?
- Q6 Did you understand when it is important to call your physician?
- Q7 Did you understand what the nurse/therapist was planning to accomplish by visiting you?
- Q8 Did the nurse/therapist visit make it easier for you to remain in your home and care for yourself?
- Q9 Were you aware that the nurse/therapist was going to discharge you from the service?
- Q10 Did you feel you could function on your own when the nurse/therapist discharged you from the service?
- Q11 If you need skilled nursing or therapy in your home in the future, will you contact this agency?

*Q12 How long did the nurse/ therapist usually stay? 10 – 20 – 30 – 40 – 60+ minutes

*Q13 did you feel the nursing/ therapy visits were Too few/ Too many/ Right number?

Q12/Q13 not represented on graph.

2006 PHYSICIAN'S SATISFACTION SURVEY

1. How satisfied are you that your plan of care and follow-up instructions have been carried out consistently?

36% Survey Return

		Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied	Did Not Use	# Not Answered
Q1	Program In General	14	4			0	9
Q2	Skilled Nursing	17	7				3

Therapies:

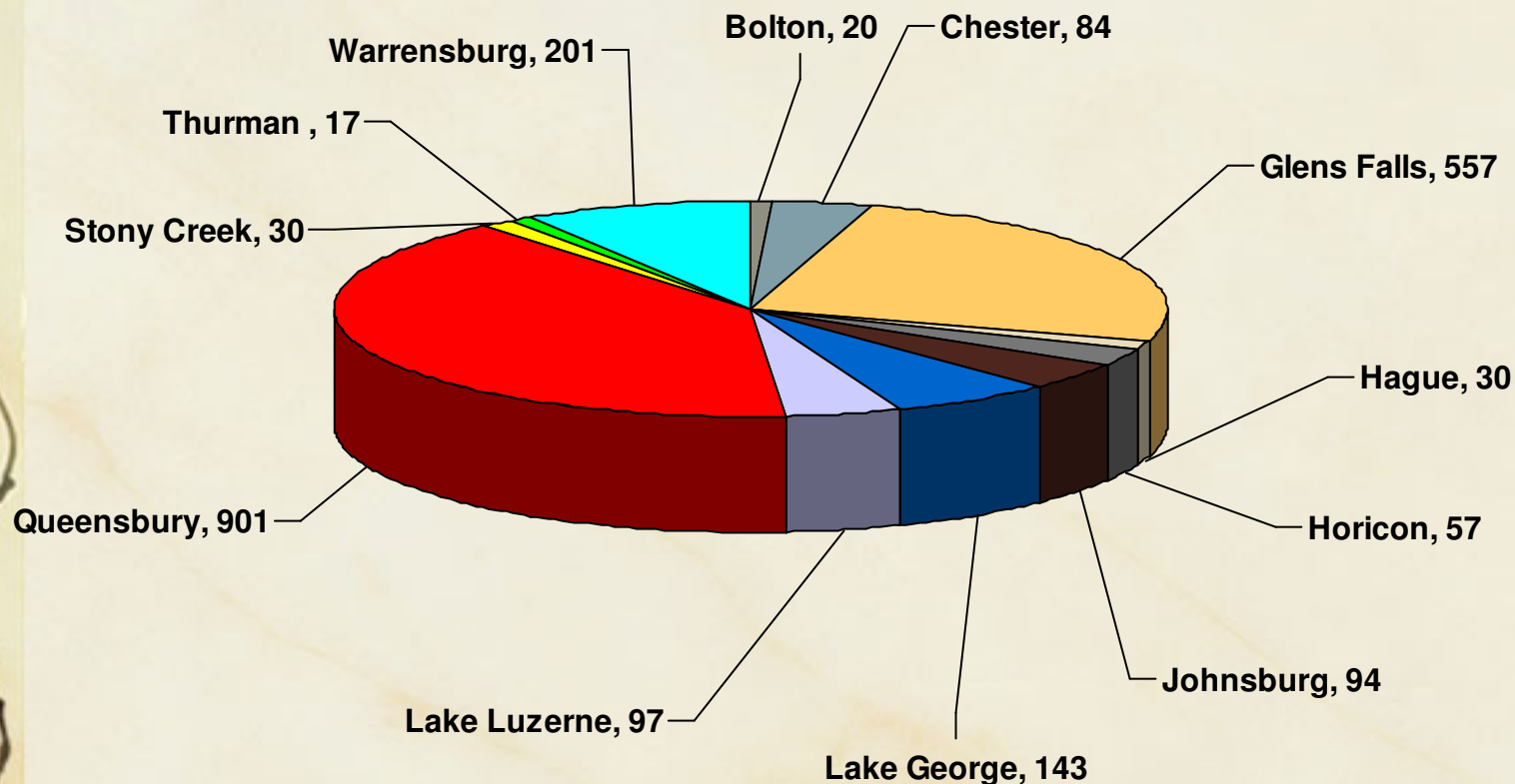
Q3	Physical Therapy	11	8			6	2
Q4	Occupational Therapy	10	8			7	2
Q5	Speech Therapy	10	3			10	4
Q6	Medical Social Worker	10	5			10	2
Q7	Registered Dietitian	9	6			10	2
Q8	Long Term Home Health Program	13	5			5	9
Q9	Home IV Therapy	12	4			10	1
Q10	Central Intake	12	4			7	4
Q11	New Tele-Med Program	2			1	12	12

12. How would you evaluate the ease of making a referral to the agency?

17 -Very Satisfied 10 - Satisfied ¶ Very Dissatisfied ¶ Dissatisfied ¶ Did Not Use

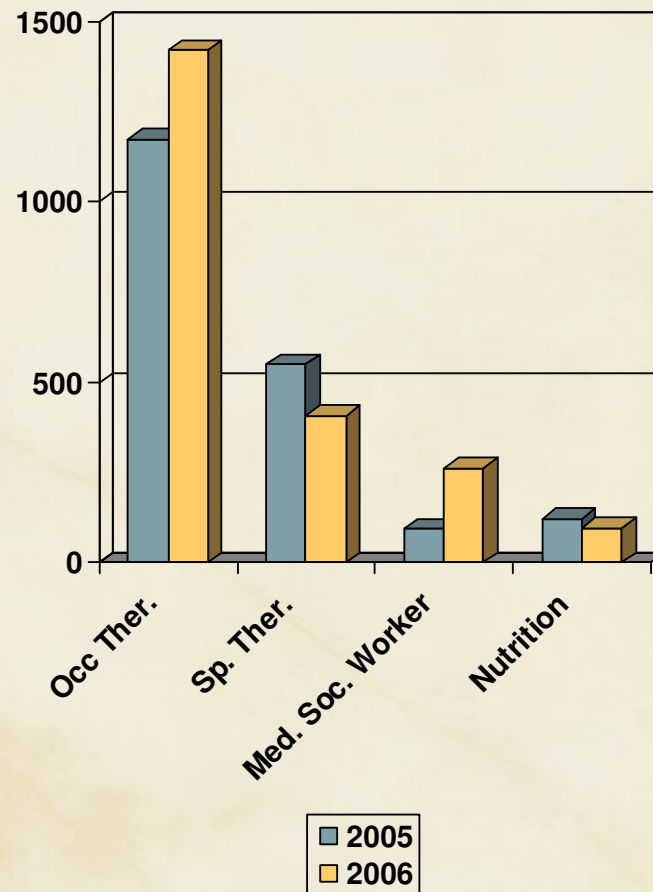
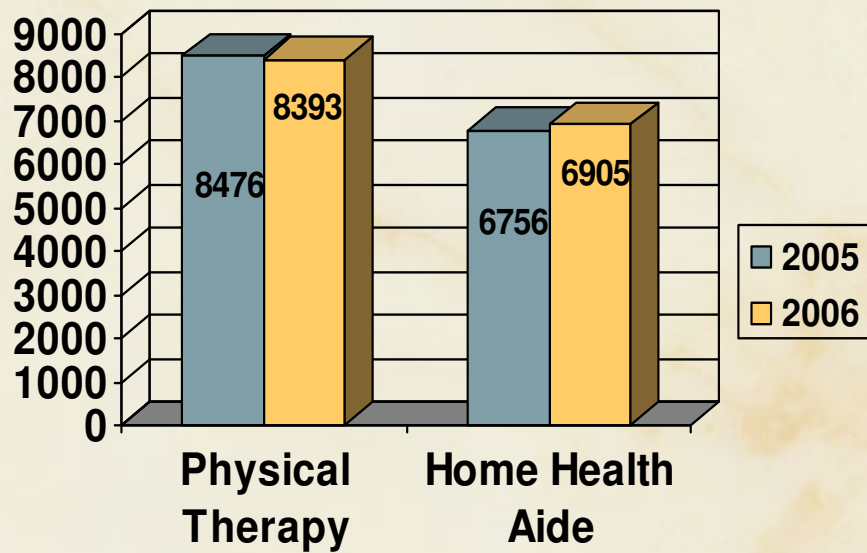
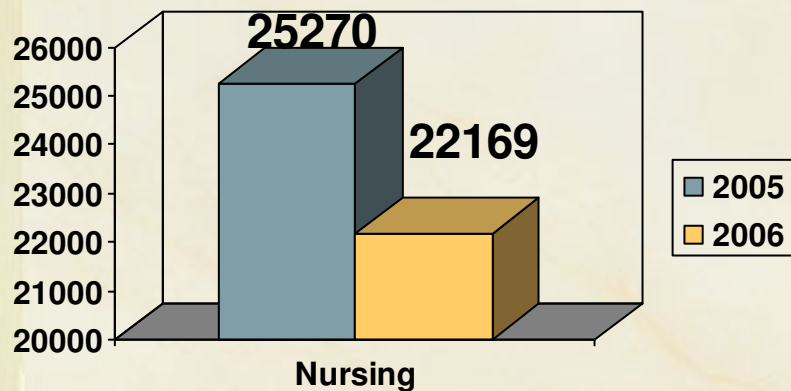
13. Have you found our response time and our communication (written and verbal) with you and your office timely and appropriate? 26 – Yes 1 - No

Cases by Town



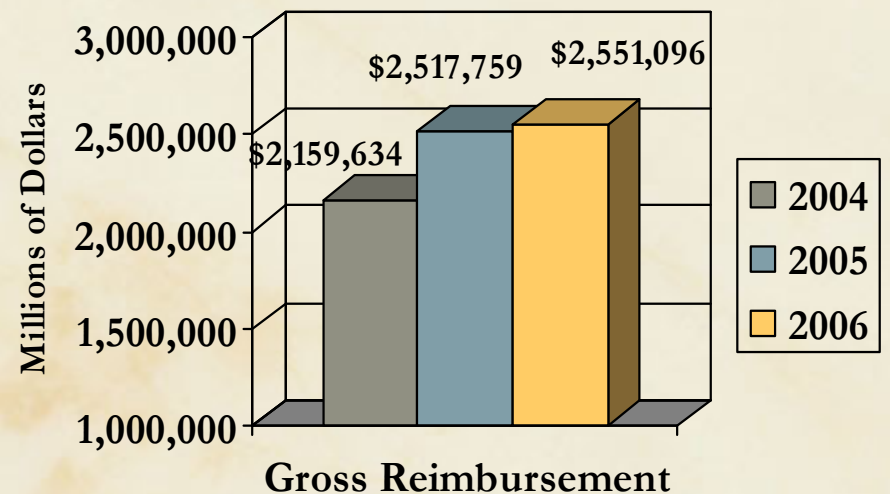
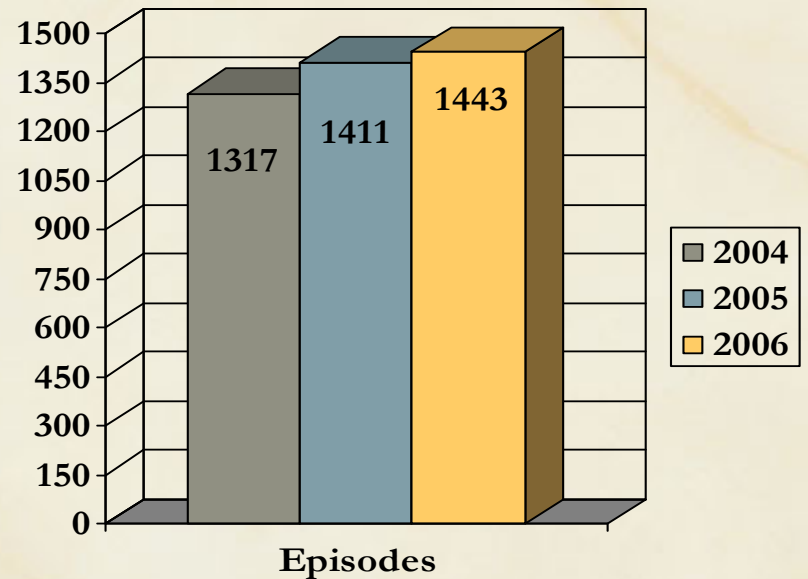
This agency continues to be the only certified home health agency in Warren County. We continue to reach out to all the communities of Warren County.

Visits by Service

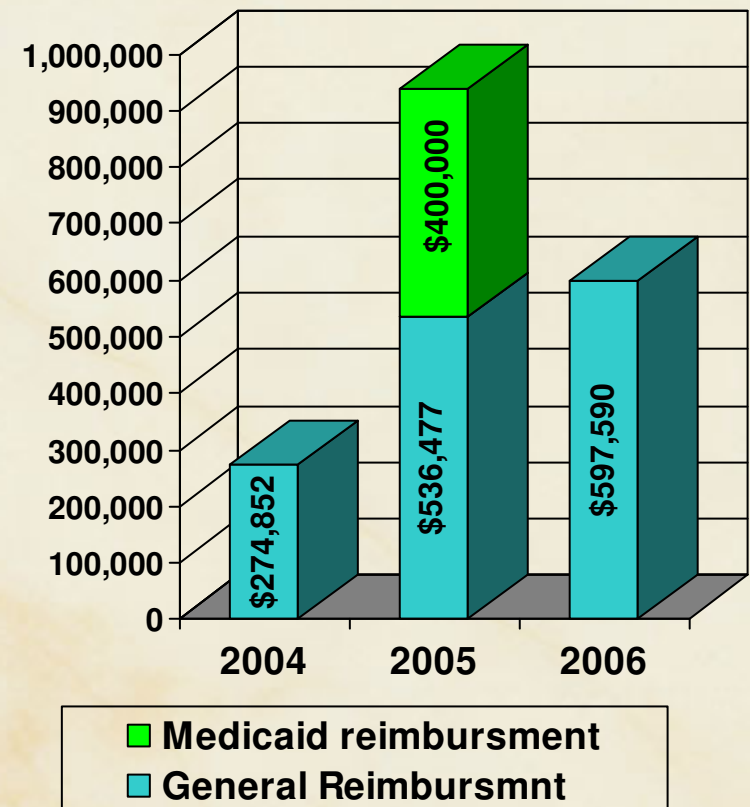
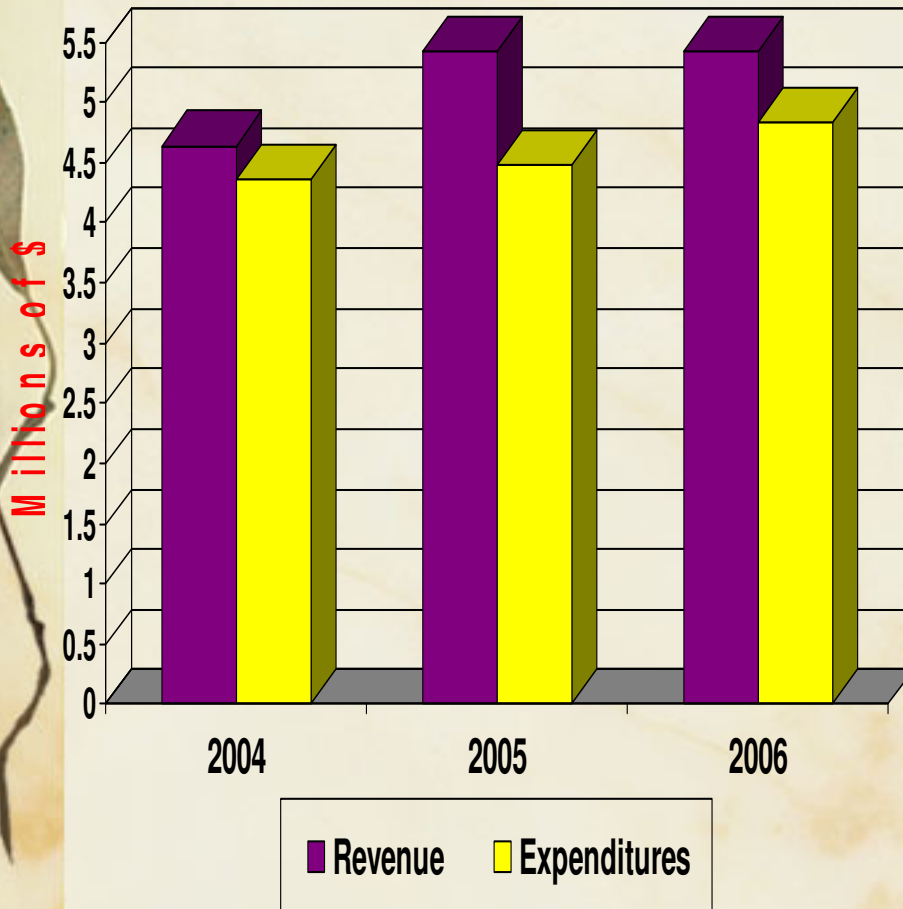


Episodes of Care

- An episode is a 60 day period of time when professional services are provided to a patient. Episodes of Care are specific to CMS (Medicare) and the reimbursement rate is based on the patient's clinical, function and service requirements (OASIS assessment) for the 60 day period.



Revenues & Expenditures – CHHA & Long Term Care





Home Care Accomplishments 2006

- 🏆 Developed Telemed Program to be one of most successful in NYS.
- 🏆 Received federal USDA Telemed Grant matching funds \$55,000. Purchased 26 additional monitors (total to date 89)
- 🏆 Expanded Telemed program to include cardiac and pulmonary diagnoses in addition to CHF & COPD
- 🏆 Have a Certified Wound Ostomy & Continence Nurse on staff. She heads Wound Advisory Board.
- 🏆 Developed/instituted 2 disease management programs (heart failure and COPD).



Home Care Accomplishments Continued

- 🏆 Improved patients dyspnea (4.3%) from 2005
- 🏆 Improved patient's pain interfering w/ activity (1.3%) from 2005
- 🏆 Decreased by 68% the hospitalization rate for patients on LTC and Telemed.
- 🏆 Developed ERP/Disaster policies and organized a committee of community partners.
- 🏆 Entered into an agreement w/ OFA and DSS as lead agencies to develop Warren Co's. Point of entry /New York Connects



CHHA Goals 2007

- Continue to enhance our Quality Improvement Program.
- Continue to work with IPRO on our communication Plan and on developing and enhancing our programs to decrease our patients' avoidable hosp.
- Develop a private pay program for Telemedicine Program.
- Partner w/ G.F. Hospital to be able to electronically access specific patient data when a patient is referred for services.



CHHA Goals Continued

- Our primary goal will be to obtain needed funding to acquire an electronic Medical Record for '08. This is critical to the growth and future stability of our agency.
- Continue to develop the county's Single Point of Entry (POE)/NY Connects: Choices for Long Term Care.



Long Term Home Health Care Program

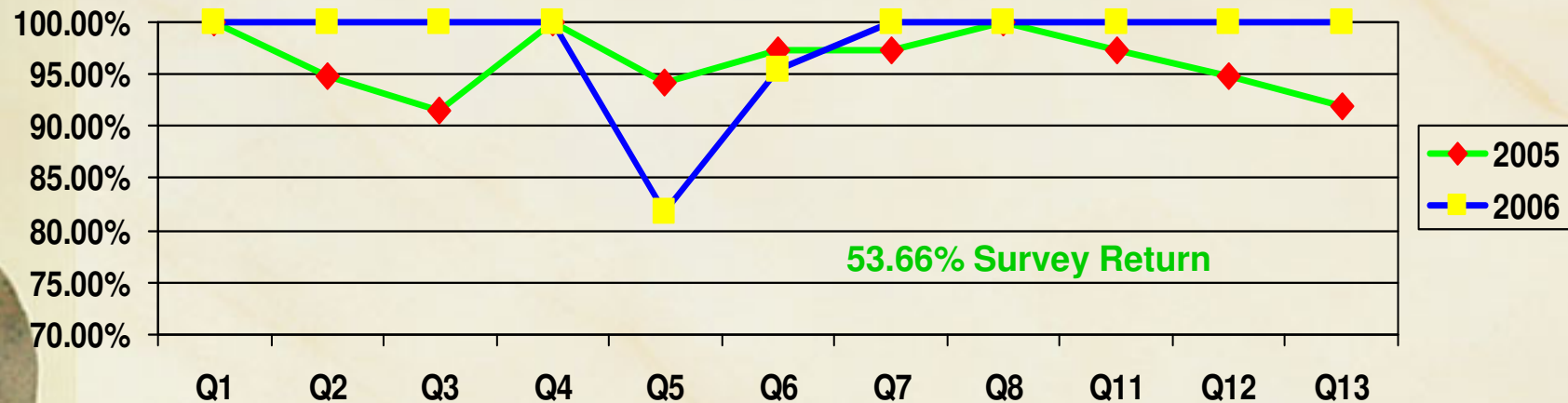
There are 19 different services available through the LTHHC:

- Skilled Nursing
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Respiratory Therapy
- Home Health Aides
- Personal Care Aide
- Homemaker
- Telehealth

*For a complete list of services please see annual report booklet

The LTHHC program is NYSDOH certified and provides Medicaid eligible clients who qualify for skilled nursing facility care. Focus is to provide a cost-effective comprehensive alternative to nursing home placement for those who prefer this option.

Patient Satisfaction – LTC 2006



- Q1 When health nurse/therapist visited your home, do you know why she/he is there?
- Q2 Do you and the nurse/therapist arrange time for the visit that is convenient to both of you?
- Q3 Does the nurse/therapist help you to understand what your medication(s) is expected to do for you, and any side effects to watch for and report?
- Q4 Does the nurse examine you when she makes a visit (i.e. take blood pressure, pulse, listen to your chest w/ stethoscope, weigh you, take your temperature?
- Q5 Does the nurse/therapist teach you the possible complications related to your illness?
- Q6 Do you understand when it is important to call your physician?
- Q7 Do you understand what the nurse/therapist is planning to accomplish by visiting you?
- Q8 Do the nurse and aide visits make it easier for you to remain in your home and care for yourself?
- Q11 Do you understand what your aide is allowed to do?
- Q12 Is your aide service adequate?
- Q13 Does your aide have enough time to complete assigned tasks?

*Q9 How long does the nurse usually stay? 10 – 20 – 30 – 40 – 60+ minutes?

*Q10 Do you feel the nursing visits are Too few/ Too many/ Right number?

Q9/Q10 Not represented on graph



Cooperative Efforts

Personal Care Aide Program (DSS) – Agency nurses provide skill assessment visits to Medicaid clients to ensure they are appropriate for the program. Currently serve 61 patients w/ PCA Program.

Consumer Directed Personal Assistance Program (CDPAP) – Program was created as an alternative to traditional PCA program. The consumer has the opportunity to manage his/her own care at home. Currently 69 clients have opted for the program

EISEP Expanded In-Home Services for the Elderly Program (OFA) – Agency nurses provide similar services as noted in personal care aide program, except these clients are not eligible for Medicaid. State funding through OFA funds. Caseload 28. New admissions 11.



Cooperative Efforts Continued

Title III E (OFA) – Program uses agency for case management and aide supervision similar to EISEP. State-funded program with a focus to provide caregiver respite through use of aides or short term use of assisted living facility. Caseload 4. New admissions 3.

Coordinated Care & Central Intake – Agency nurses work jointly w/ a DSS's CASA caseworker doing in-home assessments. The highly-skilled team helps families develop a plan to manage the care of a family member, identify sources of assistance and help make connections w/ resources.

Private Duty Nursing Assessment

An assessment of client's needs is made by CASA and an agency nurse in conjunction w/ the physician and other interdisciplinary professionals for referral to NYSDOH for authorization of PDN services.



LTHHC Accomplishments 2006

- 🏅 Used consumer Directed Personal Assistance Program to meet the needs of patients when home health aides were not available or able to meet a need.
- 🏅 Installed 22 Telehealth daily monitors in homes of patients with diagnoses of COPD and/or CHF. The goal is to increase patient compliance, decrease nursing visits and acute hospitalizations; while decreasing medical costs.
- 🏅 Completed LTHHC Program manual and made it available for reference



LTHHC 2007 Goals

- ❏ Maximize our allowed census/slots of 70 clients.
- ❏ Have in place a Point of Entry system (created by the NYS Office for the Aging) that is easy to understand and use; provides unbiased information about Long Term Care options available; and involves the consumer and caregivers in planning, evaluation, and decision making regarding consumer needs and preferences.
- ❏ Continue w/ Telehealth monitor use for appropriate patients w/ CHF and COPD and expand to those w/ high risk factors for hospitalizations.



LTHHC Goals continued

- Institute the Med Partner Program via Telehealth Program for those needing a daily reminder for their medications.
- Present proposals to NYSDOH regarding changes as part of restructuring of Long Term Program for LTHHC waiver due for recert. in Dec '07



What the Future Holds

- The Home Care Staff will continue to prepare for the future of the certified agency through the Quality Improvement Process. Development of new programs and enhancement of existing ones continues to be a top priority.
- Center for Medicare & Medicaid Services encourages all providers to prepare for:

Pay for Performance: Tying a portion of reimbursement to a delivery of care that has been proven effective.

Standardized Assessment/Quality Measurement: across (post – acute) health care settings.

Integration of Measures of Process and Systems: Telemed Program.

Electronic Health Record: (EHR) to ensure future stability.



Division of Public Health

An ounce of prevention is worth a pound of cure!





Prenatal Program

Program Highlights

- **Teaching** – moms the importance of proper nutrition, not using drugs (legal/controlled), signs of pre-term labor, and skills to help ensure a healthy labor and delivery.
- **Provider Referral Service** – working with providers to get referrals on new moms, high risk moms, and moms who might benefit from services.

Nuts and bolts

- Warren County received 166 prenatal referrals in '06.
- The teen pregnancy rate for Warren County has remained constant at about 2.3% over the last 5 years (the rate for '06 was 1.3%).
- Much time is spent making home and other visits and tracking down clients who have moved.

Childbirth Education

Childbirth Education

- Warren Co. has 4 certified childbirth Educators
- Classes are offered in 6 week sessions (1 class a week) or a weekend class to accommodate different schedules.
- A fee of \$35.00 is requested, but is waived in cases of financial hardship.
- Class is open to anyone, with preference given to Warren County Residents.

Class Focus

- Preparing for labor and delivery, breathing techniques and exercises
- Discussion about natural childbirth, C-sections and medications
- Tour of GFH Snuggery
- Focus on postpartum and infant care and breastfeeding





Putting the Natural Back Into Childbirth

Natural Childbirth Forum, May 2006 at Warren County Public Health

- Designed to encourage women and their partners (pregnant or trying) to try natural childbirth.
- A panel of midwives, childbirth educators, women and partners was assemble to discuss their labor and deliveries without medical intervention and promote natural childbirth. Panel also answered question from the audience.
- Following panel discussion there was a fashion show and yoga demonstration for pregnant women.
- Informational displays were available from area services that serve area families.
- The forum was filled to capacity.

Maternal Child Health Program

Program Criteria:

- First time mothers, breastfeeding mothers, and mothers and infants with health or social concerns (referrals received from hospitals, physicians, WIC, etc.)

Action Taken:

- Potential patients are contacted by telephone and a home visit is offered.
- In cases deemed “high risk” a home visit is automatically attempted.
- Home visits are used to provide parenting information, physical assessment, immunizations and general health information

In 2006 Warren County received 462 newborn referrals. This represents 80% of newborns.



Above: A Public Health nurse prepares to give a baby a check up at a home visit.

Lactation Program

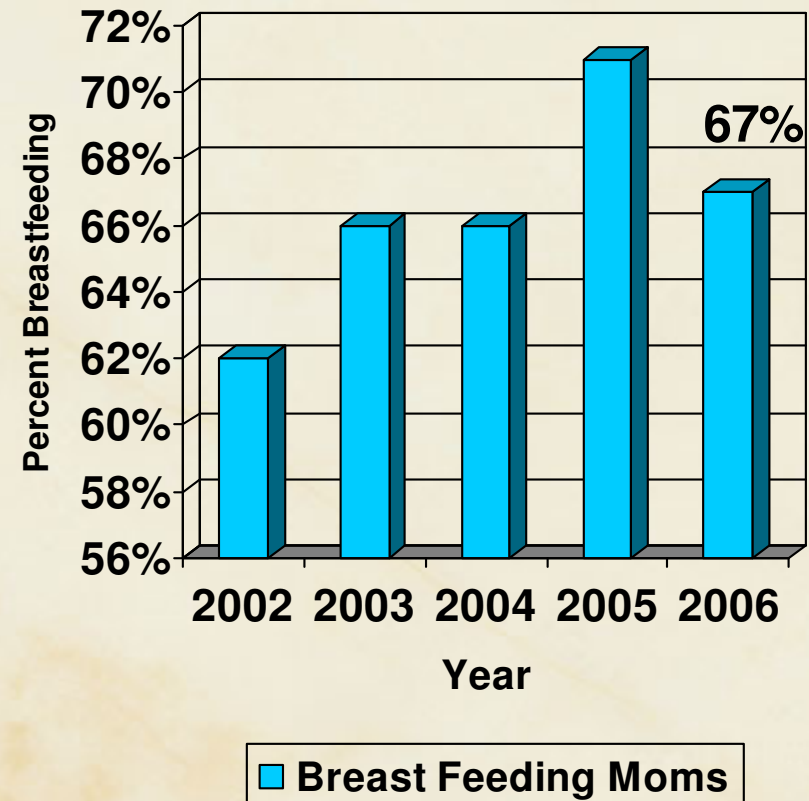
Resources/Goals:

- Warren County employs 3 certified lactation consultants
- Looking to increase breastfeeding to 75% during early postpartum period (national goal).

Why lactation program is so important

- Breastfeeding promotes good health for both mom and baby
- Helps control WIC food budget
- Provides a mechanism for smooth transition to pediatric care of the infant, including good communication between obstetrics and pediatric care providers.
- Provides a resource for mothers and families as needs change.

Breastfeeding



Graph shows breastfeeding numbers for early postpartum period. However, long-term tracking (5-6 mths.) is not possible. National goal for long-term is 50% breastfeeding.



Filling The Gaps

Parenting Program

- Conducted by a PHN with special training
- Conducted in collaboration with 9 other agencies including Warren Co. Family Court, DSS, Cornell Coop., YMCA, GFH, Glens Falls City Schools

• Program is designed to enhance parenting skills and teach about child development.

• Workshops include Parenting Skills, Strengthening Families, and Parenting Apart. 75 parents participated in at least 1 workshop impacting 125 children. These numbers represent a ninety-percent increase from last year.

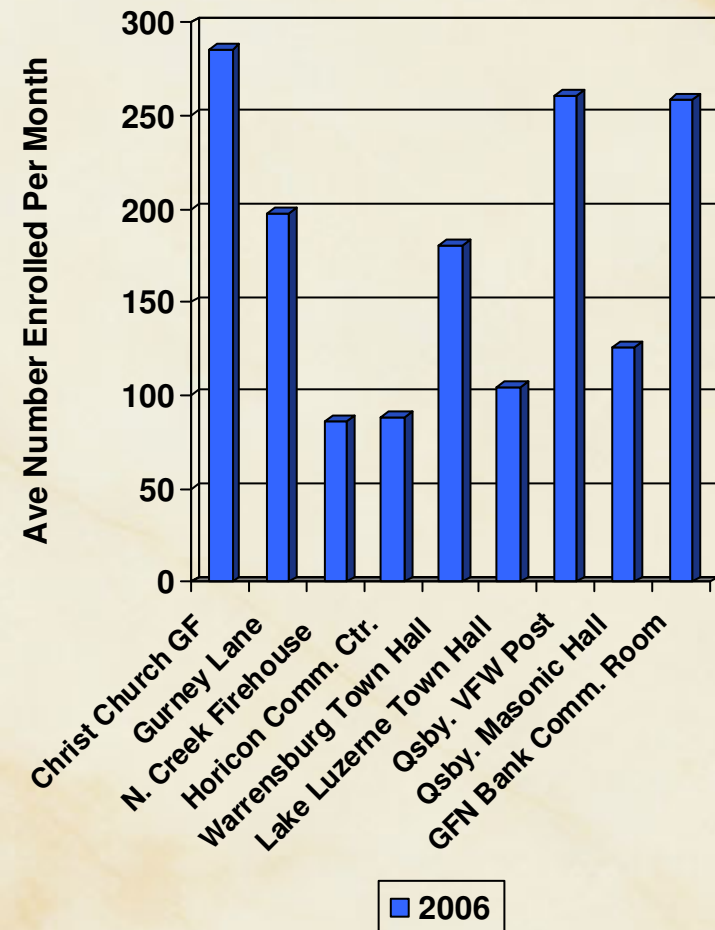
Children With Special Healthcare Needs Program

- Focus on delivery of health services to mothers and children who exhibit a need for health services beyond that required children generally.
- Program is grant funded
- This program continues to identify important gaps in children's health services

WIC Program

- WIC has 13 contracted vendors serving its clients in Warren County.
- In '06 Warren county grocers redeemed \$1.16 million in WIC vouchers.
- In 06' Warren County WIC received just over \$10,000 in grant funding to increase education targeting childhood obesity.
- Warren County WIC was able to implement 3 new programs focused on increasing physical activity and better nutrition with their grant funding.

See next slide for program summaries



Total number of clients per month (ave.) was 1589.

WIC Working to Create Healthy Families

The Butterfly Project – designed to educate parents about what developmental milestones to expect their children to reach from birth – 5 yrs. Teaching tools that were designed to give parents the ability to assist their child with development were distributed. A total of 1,799 teaching tools were distributed with a 92.5% success rate.

Recipe Challenge – Focus was to encourage young families to cook and eat together, as well as trying new foods. Recipe cards were chosen at each appointment the more recipes a family tried the more incentives they received. Over 1,700 recipes were prepared and evaluated. 73% of the recipes received “yummie” marks.

Great Moves Project – Designed to encourage families to become more physically active. Clients signed a contract and set goals for activity and diet. Those who reached their goals earned prizes for the children and gift certificates for sneakers for the parents. 31 women and 24 children met their goals



Right: Pictures show participants taking part in programs and receiving incentives for successful completion of programs.

Child Find

CHILD FIND

- A statewide program that focuses on children ages birth – 3yrs.
- Helps identify and provide services needed for best growth and development in a child's early years through periodic developmental screenings.
- EI referrals are based on screenings.
- Program is funded through a contractual state grant.

Highlights:

Program continues to grow yet remains very cost-effective.

It has heightened awareness to developmental expectations for children.

Has served as an educational opportunity for parents.

Right: A Public Health Nurse does a developmental screening as part of the CHILD FIND program. She is also using Language Line a tool used to communicate with non-English speaking families.



Child Find Continued

By The Numbers

- **77-80 active children**
 - 22 infants born <34 wk gestation
 - 6 born <32 wk gestation
 - 3 born <28 wk gestation
- 1/2 of admissions to the program are do to premature births. This indicates a need to focus on reducing the number of premature babies being born.
- One-fifth of admission are due to issues of parenting or mental health concerns.
- 9 sets of new twins were admitted to the program in 2006

New Resource Tool Completed

- Evidence points to sleep deprivation as a major factor contributing to hyperactive, impulsive, and inattentive behaviors in children's everyday lives.
- Regular sleep routines are essential for a child's normal growth and development.
- Research was conducted on child sleep routines and the data was utilized to create a brochure/teaching tool





Early Intervention Entitlement Program

EI offers 16 different services including:

PT, OT, ST

Nutritional Services

Transportation

Service Coordination

Nursing Services

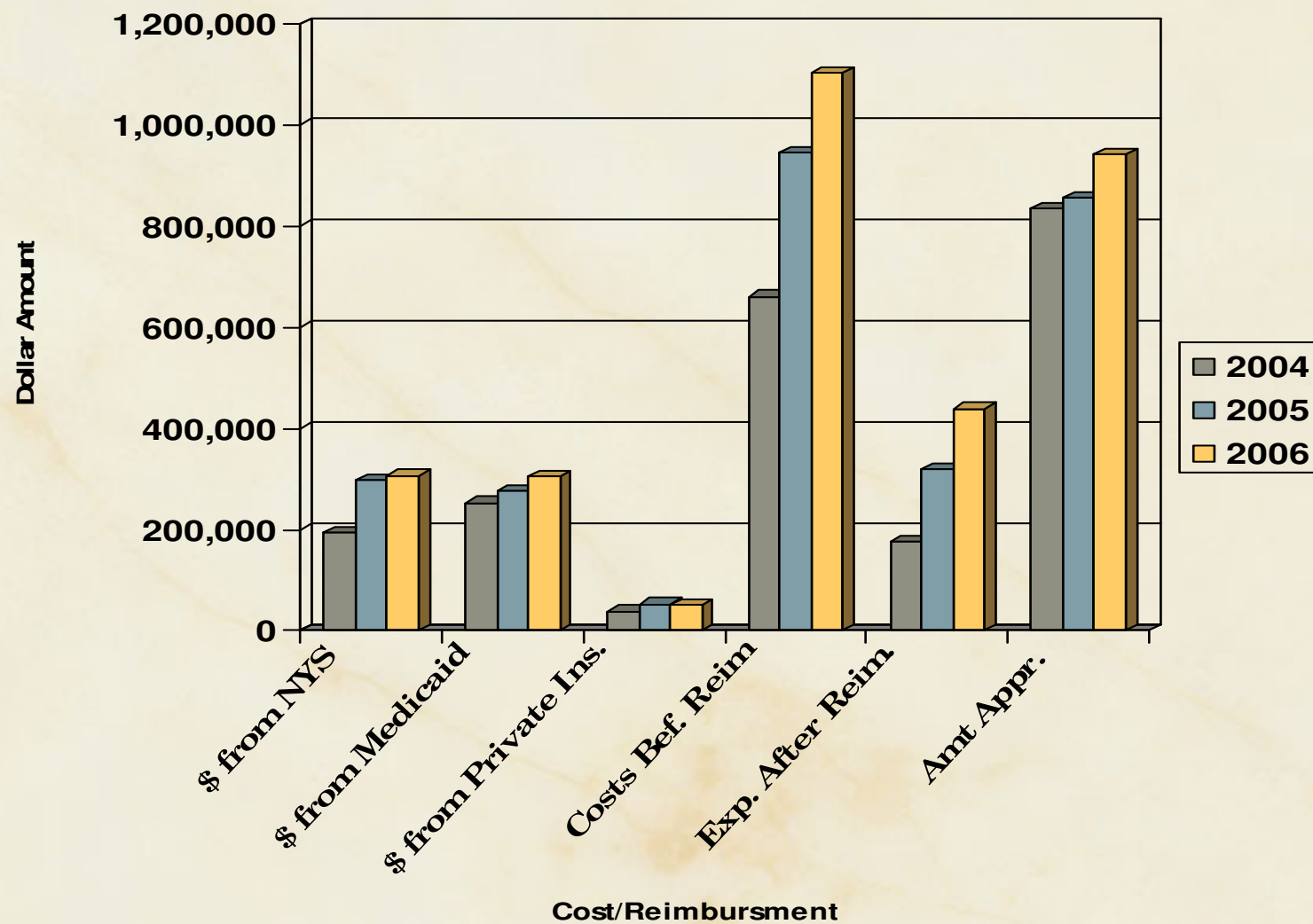
Special Instruction

Eligibility Criteria:

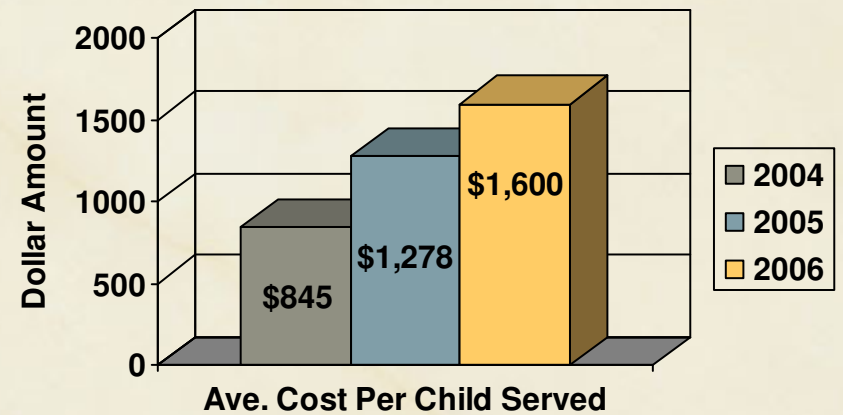
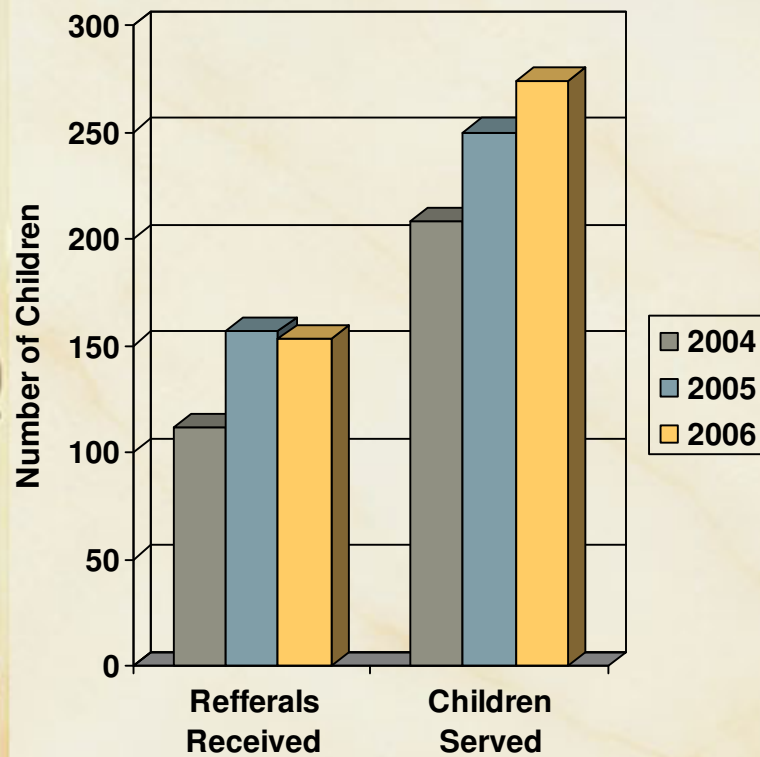
- Child must be under 3yrs. old and have a developmental or diagnosed physical/mental condition w/ high risk of delay in the following areas
 - Physical Development (vision and hearing included)
 - Cognitive Development (thinking process)
 - Communication (understanding and expressing language)
 - Social or Emotional Development
 - Adaptive Development (self-help skills)

For complete E.I. service list see annual report booklet

EI: What It Costs



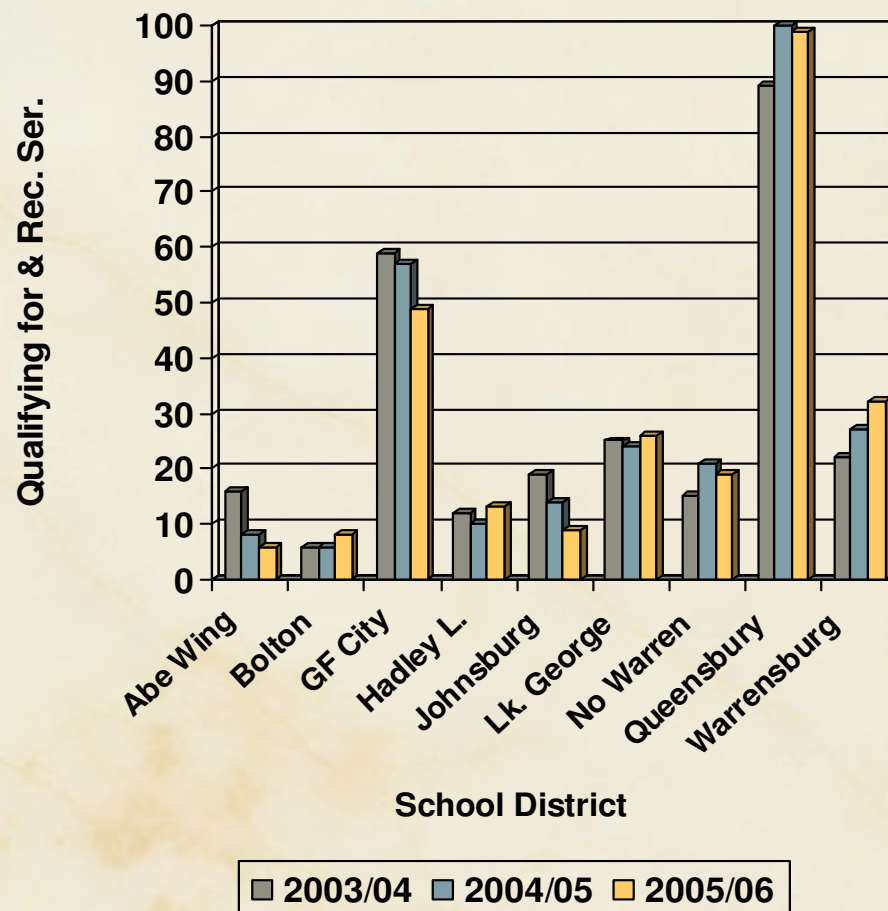
More E.I Statistics



Preschool Program for Children With Disabilities

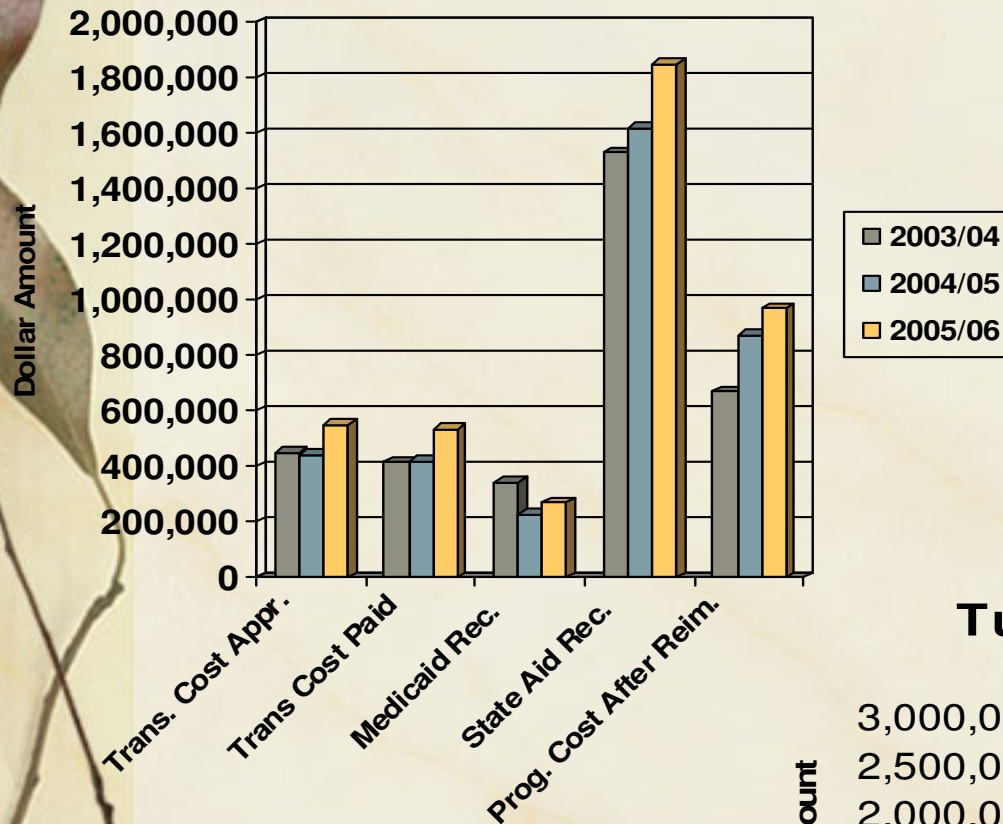
- An entitlement program for children 3 – 5 years old
- Referrals made in school district to CPSE Chair
- Voluntary enrollment by parents
- County serves as voting rep and oversees billing/reimbursement
- Payment Sources: State Ed, Medicaid, and Private Ins.

Where Services Are Received

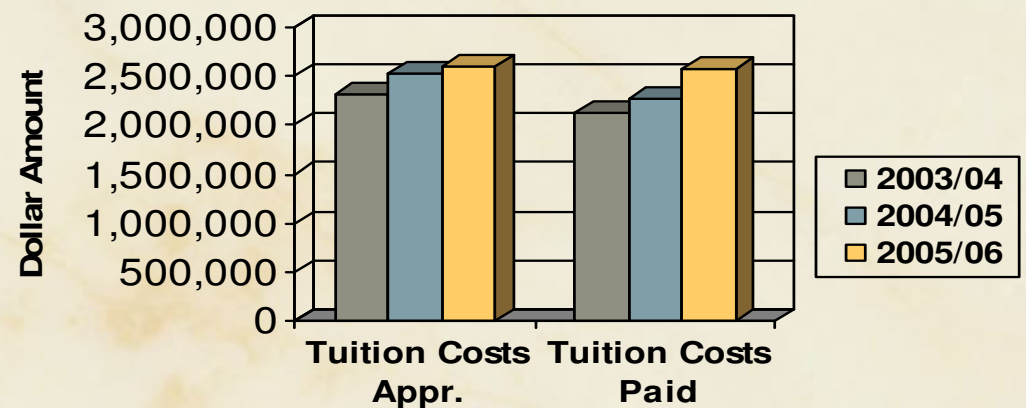


Pre School Breakdown

Costs Approved/Paid

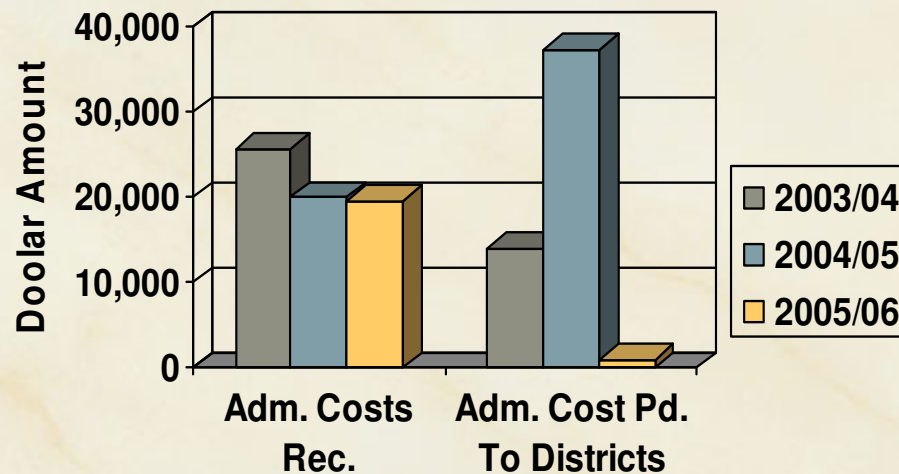


Tuition Costs Approved/Paid

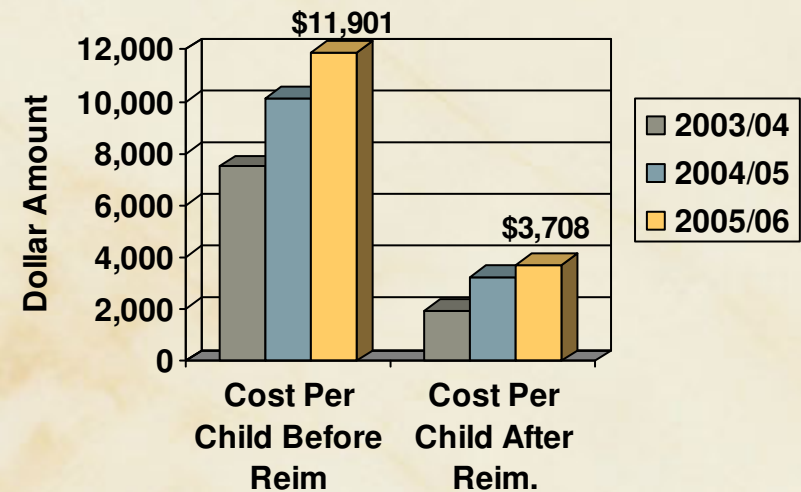


Preschool Program Continued

Aministrative Costs



Average Child Costs



Lead Poisoning Prevention Program

What is It

- Grant Fund by NYSDOH (\$25,000)
- Program focuses on prevention education, screening, and follow-up
- No cost service for families

Program Importance

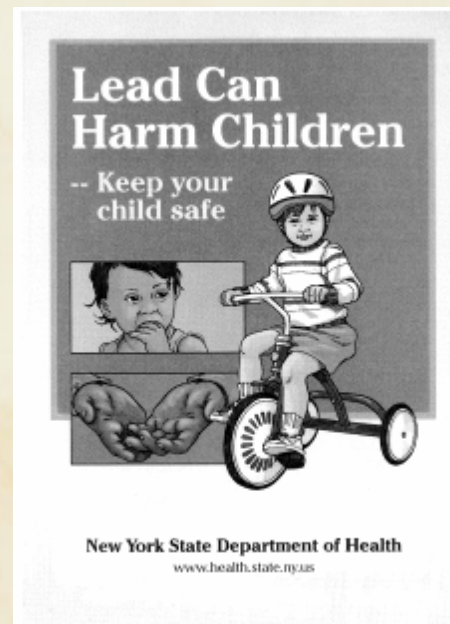
Lead Poisoning is PREVENTABLE!

Lead poisoning can lead to health problems including

- Neurological disorders
- Growth and development deficiencies
- Mental impairment

By The Numbers

- Warren County tested 835 children in 2006.
- Last year Warren County tracked 6 children with elevated lead levels.



For complete lead level breakdown please see annual report booklet.

Infection Control Stopping the Spread

What it Takes:



Collaboration between Health Services, physicians, Glens Falls Hospital, and the NYSDOH.



Follow-up by a Public Health Nurse to provide teaching to ensure appropriate treatment, and prevent/assess secondary exposures.

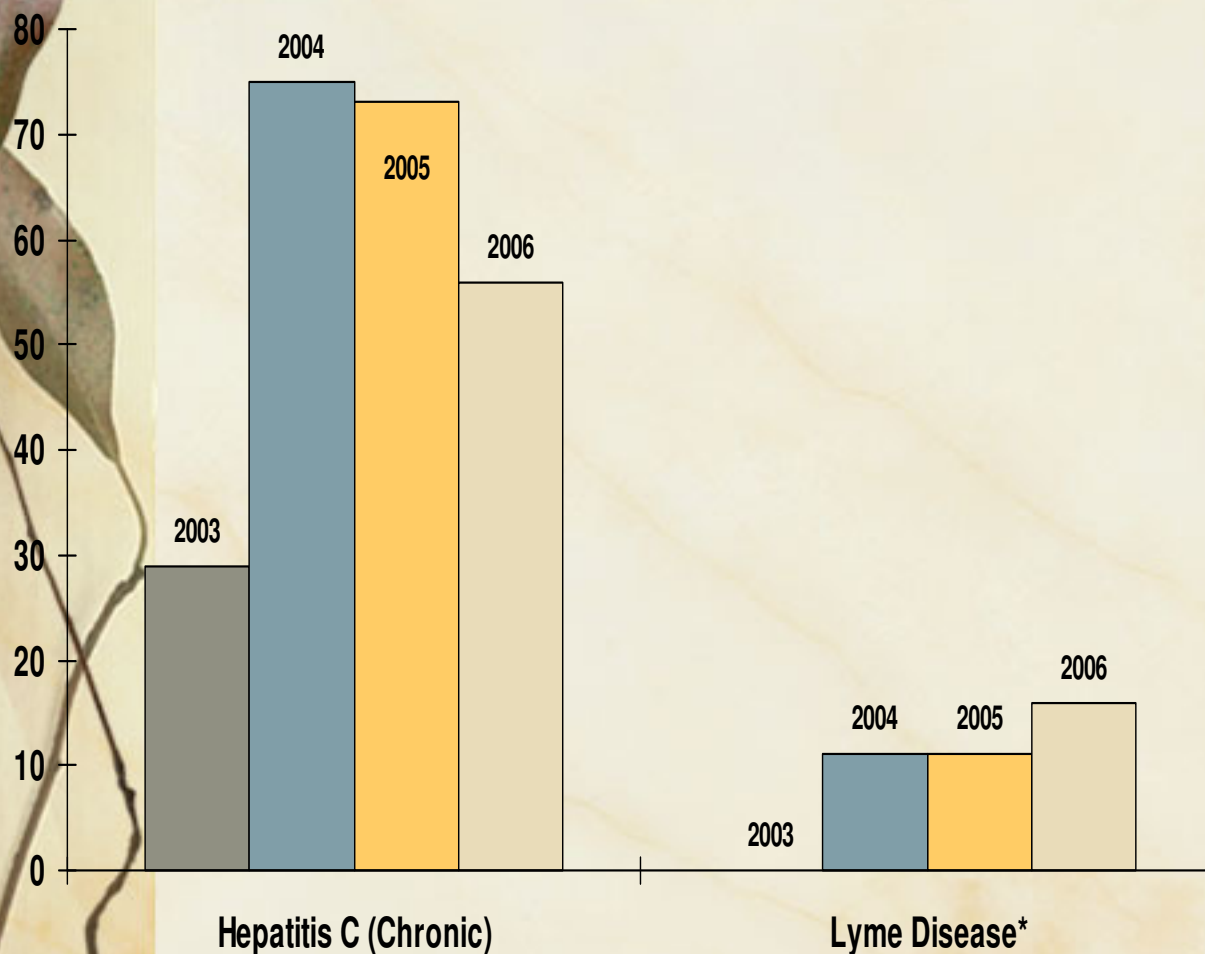


Appropriate and timely reporting to NYSDOH and regular meetings to review infection control protocols and policies

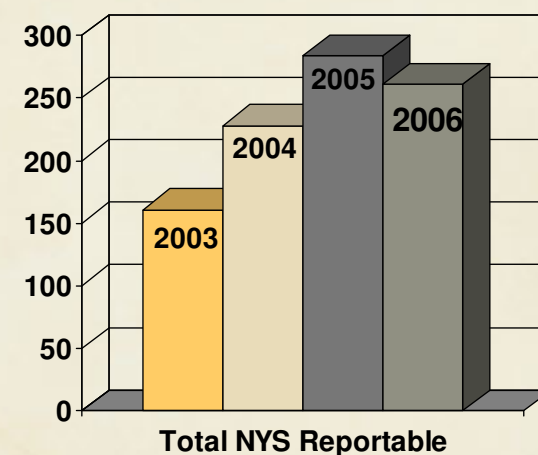


Although no longer at the forefront (general emergency preparedness the main focus) the threat of bioterrorism is still a driving force when creating Infection Control Policy.

Reportable Communicable Diseases With Lab Confirmation



Total Reportable Diseases



Warren County is required to report on 68 different diseases. The above graph shows the total reported cases including STD's. 2005 there were 261 reportable cases.

*Warren County sent 119 ticks for identification in 2006. 96 were identified as deer ticks, the main vector for Lyme Disease transmission. Over the last 5 years approximately 80% of the ticks identified in Warren County have been deer ticks.

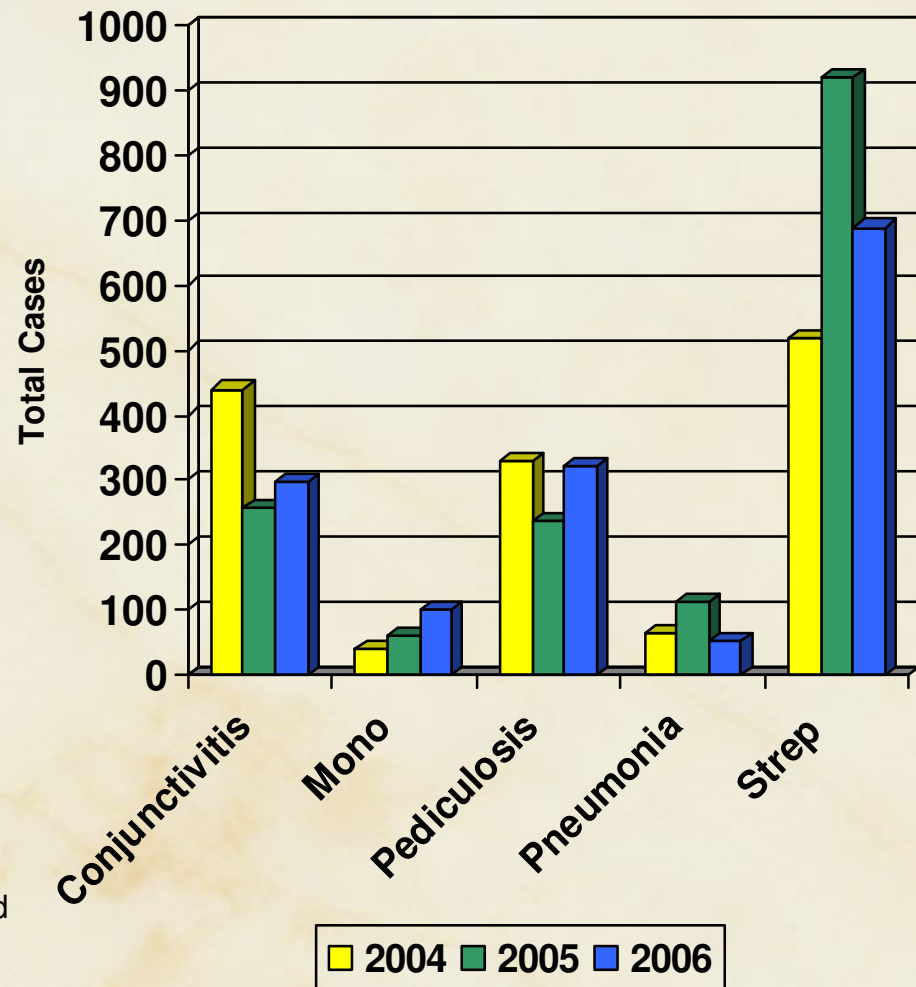
**Disease graph does not include STD's. However total reportable graph includes all reportable diseases

Disease Reporting From School Districts

- Monitoring school health is one of the best ways to track disease within the county.
- Schools are requested but not required to submit monthly reports of physician diagnosed diseases and conditions.*
- Warren County's school nurses report on 20 different diseases.

*Public Health has no way to ensure 100% of reported diseases were physician diagnosed. Information only represents student health concerns reported to the nurse.

Top 5 Diseases of Last 3 years



Rabies Program



Warren County's Rabies Control Program follows-up on all animal bites/exposures.



All animal bites/exposures are mandated to be reported to the victim's county of residence.



2002 saw a new rabies law go into effect requiring all dogs, cats, and ferrets be vaccinated by 4 months of age.



Warren County offers 2 rabies clinics a month (Feb – Nov) with at least 1 clinic held in each town.*

Above: A dog receives a shot at a Warren Co. rabies clinic.

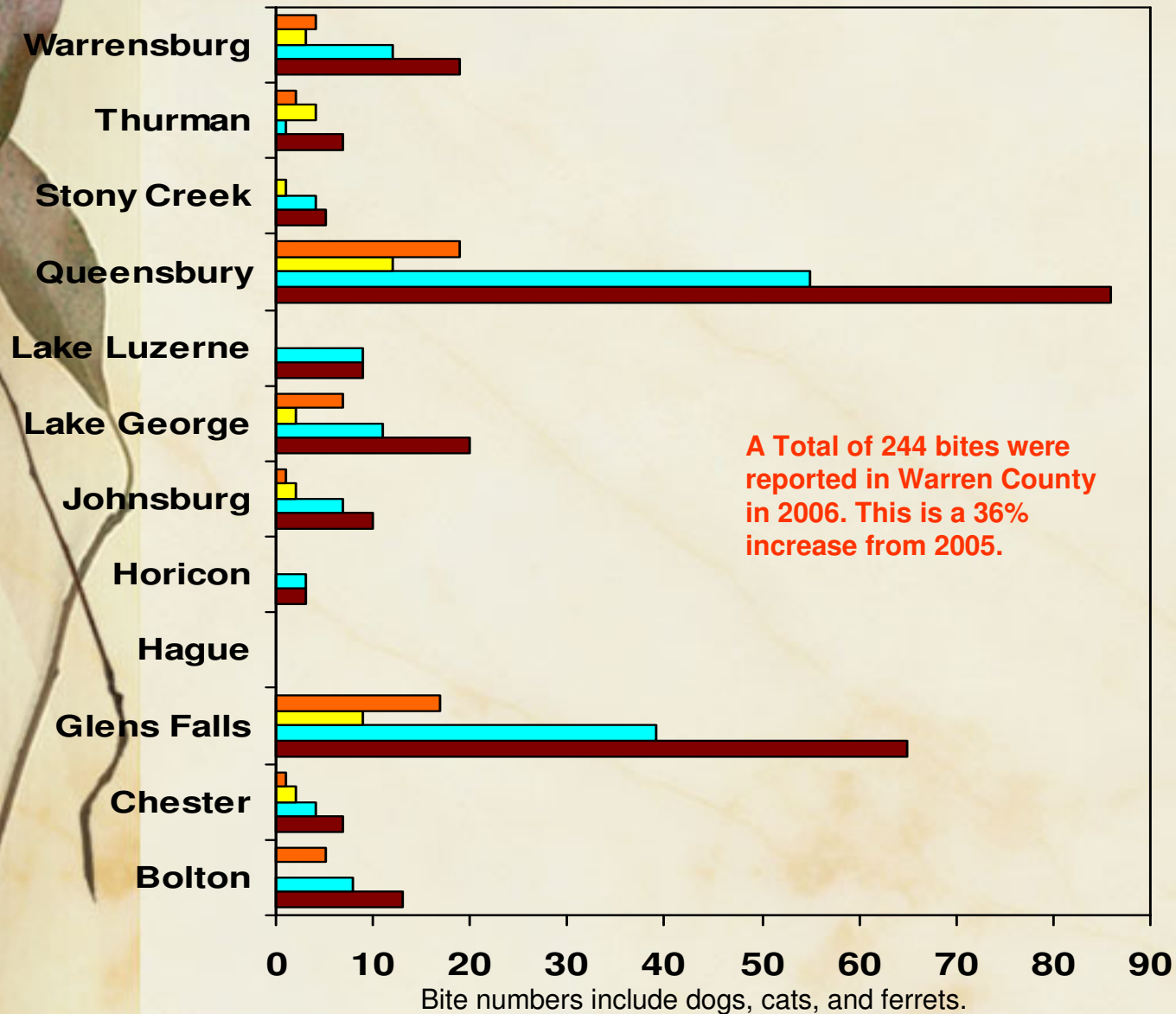
Below: Dog owners waiting to enter a rabies clinic with their pets.



***Counties are required to offer at least 1 rabies clinic every four months**

Animal Bites 2006

Where They Bite



Other Interesting Rabies Facts



Warren County offers 23 clinics a year and vaccinates an average of 1,150 animals.



In 2006 dog bites were up 26% and cat bites were up 78% from 2005.



In 2006, of the animals involved in bites that had known vaccination status 81% had been vaccinated up from 77% in 2005. However, out of the total number of bites recorded 23% of the cases had an unknown vaccination status.



Warren Co. had 1 raccoon test positive for rabies in 2006.

Emergency Preparedness

Goals:

- ④ Develop an emergency response protocol for public health emergencies including pandemic influenza planning
- ④ Identify incident command leaders, role players and networking partners.
- ④ Hold trainings for essential staff in preparation for a real emergency.
- ④ Assisting small businesses and special needs populations to prepare for emergencies
- ④ Offer programs to the public on family emergency preparedness.



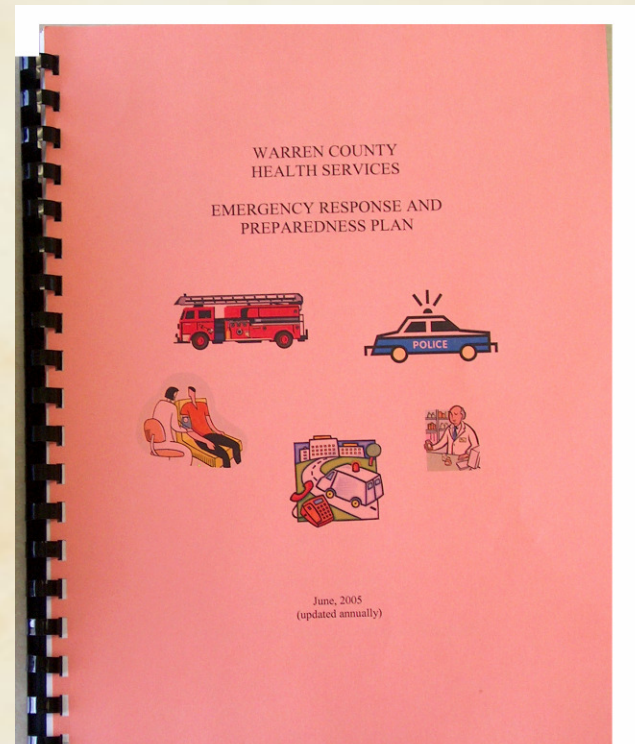
Above: Nurses work with a patient at a mock small pox drill.

Below: A POD set-up to respond to an emergency



ERP Progress

- Held several successful tabletop drills with our networking partners.
- Held several Family Emergency Preparedness programs with county staff and the public.
- Increased education about ERP by presenting at town board meetings and material distribution (i.e. pamphlets, brochures, flyers, etc.).
- Identified an incident command protocol.
- Developed a database of volunteers and networking partners.
- Identified POD centers throughout the county to be used in the event of a disease outbreak or bioterrorism attack.
- Public Health & CHHA each have an active ERP team that meets quarterly



Immunization Action Plan



Warren County is a member of a seven county consortium whose mission is to address the immunization status of children.



Upper Hudson Primary Care Consortium serves as contractor. Funding is allocated based on individual county's needs.

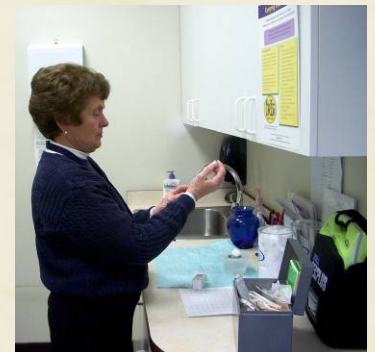


Regular meetings are held to address progress, objectives and identify changes and concerns as they occur.



There are 10 objectives for the Immunization Action Plan that focus on collaboration, education, access, and assessment.

Right: A clinic nurse draws up a vaccination



Flu Vaccine Administration



The flu vaccine is usually targeted at populations most likely to suffer complications from the flu.



These groups include senior citizens (65+), adults and children with chronic illness and healthcare workers.

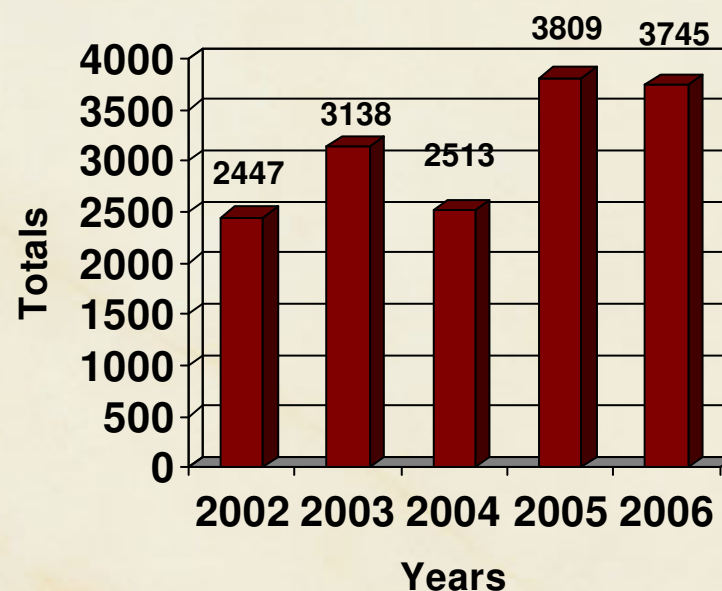


Over 3,000 people a year receive County administered flu vaccine. 2006 saw no flu vaccine shortages making the vaccine available to everyone with no restrictions.



Warren County held 44 clinics in 2006.

Flu Vaccine Administration*



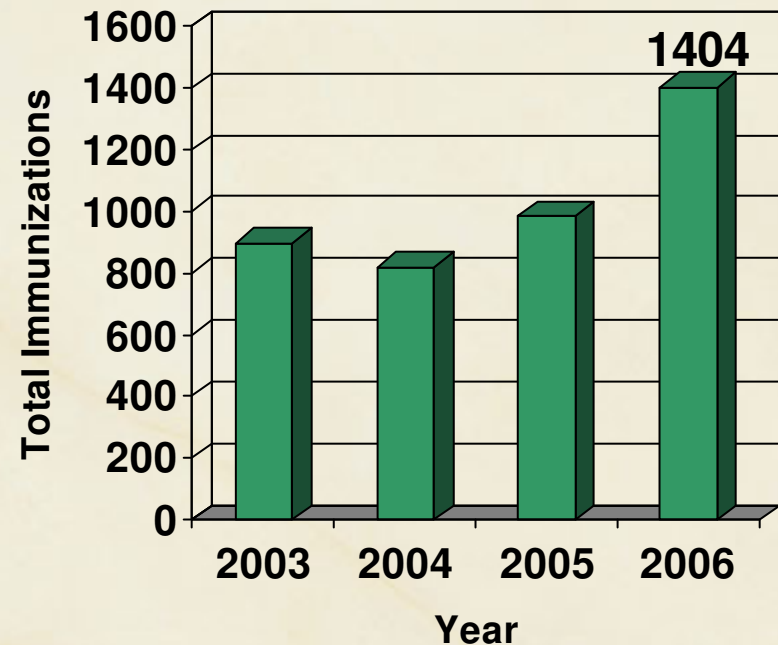
■ Flu Vaccine Administered

*For a complete flu/pneumonia vaccine breakdown please see annual report booklet. Graph does not include pneumonia vaccinations.

Office Immunizations

- Immunization totals include 15 different diseases.
- Warren County has averaged over 1,000 office immunizations a year for the last 5 years.
- Warren County participates in a state-funded Hepatitis A & B vaccination program in the county jail. In 2006, 393 ('06 First full year) new and former inmates were vaccinated.

Office Immunizations



■ Office Immunizations



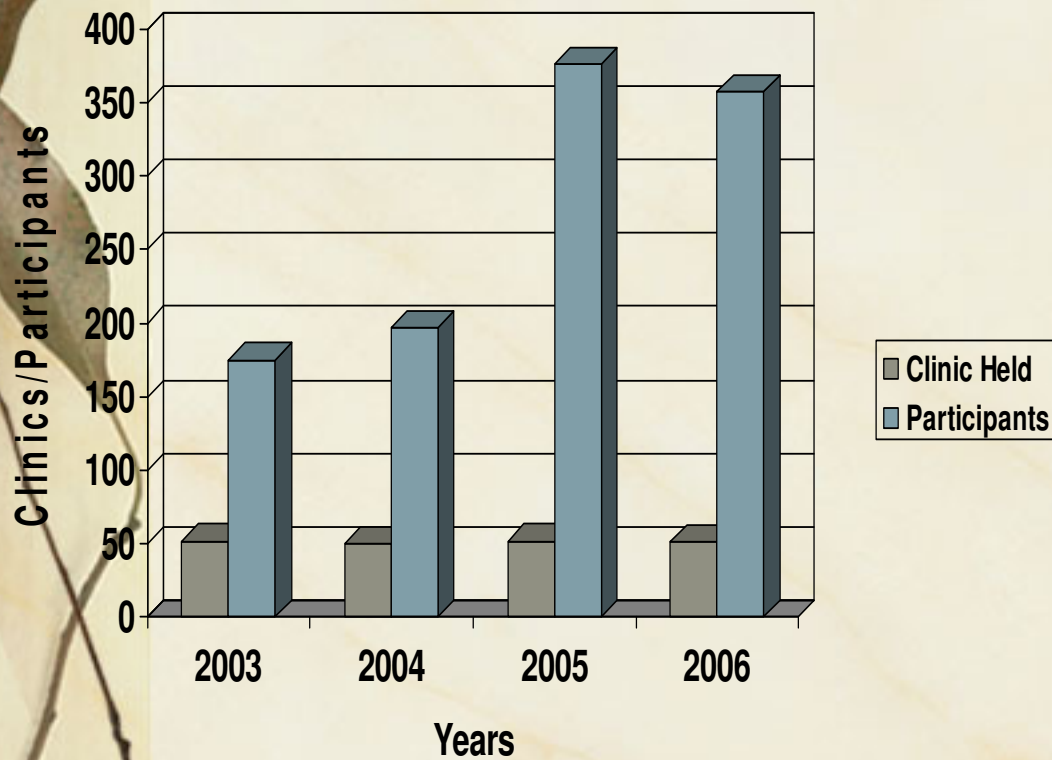
Left: A clinic nurse gives a PPD test at the Public Health Office.



STD Clinic Highlights

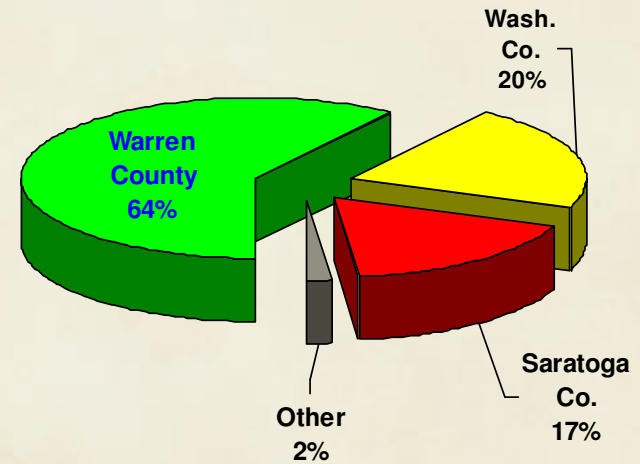
- The STD clinic is a cooperative effort between Warren and Washington Counties, but the clinic is open to anyone.
- STD clinic reaches a large number of higher risk uninsured clients.
- STD clinic is part of the NYSDOH Free Hepatitis Program, which means every client is offered free Hepatitis A+B vaccine.
- STD clinic continues to have very high attendance with many clients seeking Rapid HIV testing which is available at the clinic.
- Majority of clinic participants are men. It is believed STD clinics fill a gap for men's reproductive health (lower clinic utilization by women may be due to access to OBGYN's and Planned Parenthood).

STD Clinic Trends



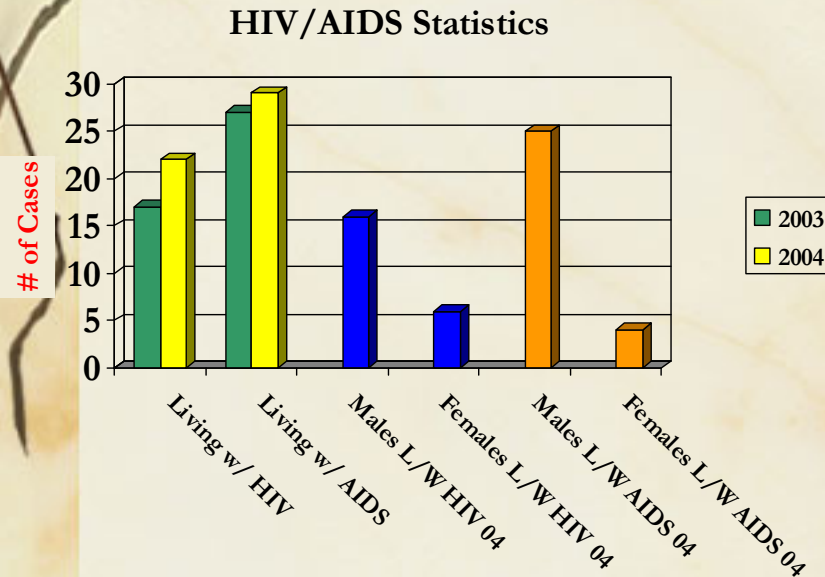
The Warren/Washington County STD clinics have seen a 168% increase in attendance since 2001

Who Participates

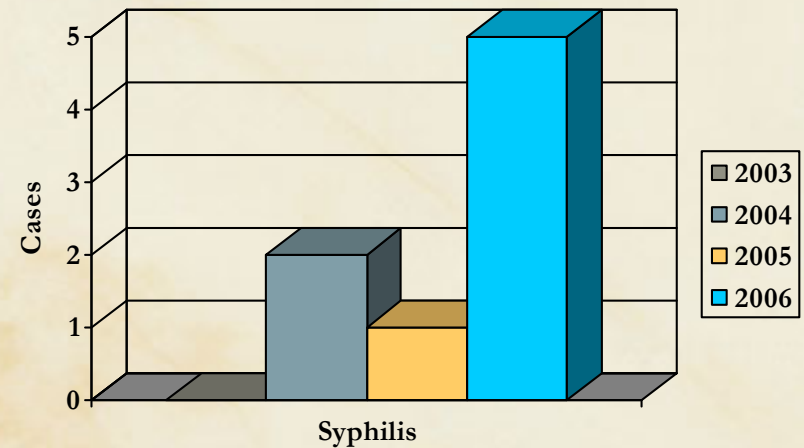
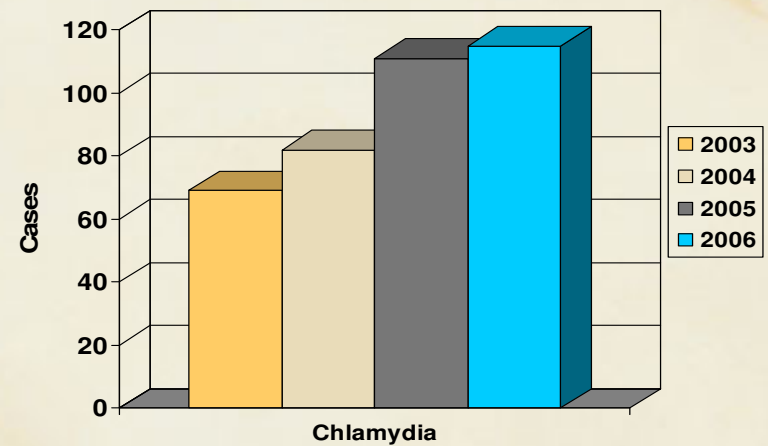


Interesting STD Disease Trends

- 236 Clients utilized the Rapid HIV testing.
- Clients are tested using a Rapid HIV Test, results in 20 minutes.
- There were 4 cases of pediatric HIV and 1 case of pediatric AIDS ('04 stats most recent)



Specific Disease Trends



For more STD information please see annual report booklet.

Other Clinics Offered By Public Health

Blood Pressure Clinics

- Offered at all meal sites throughout the county.
- General health information is available at each clinic.
- BP clinics are a great way to interact with community members.
- The Warren County clinic team took over 1,100 blood pressure readings in 2006.



Above: A woman has her blood pressure checked by a clinic nurse at the Warrensburg blood pressure clinic.

Clinics Continued

Well Child Clinic

- Held monthly
- Continues to fill a service gap by assisting families in securing primary and preventive care.
- Clinic used to promote Child Health Plus insurance. Nurses assist with application process
- Numbers have remained constant or slightly increasing showing a continued need.



Left: Mom and child attend a Well Child Clinic.

East Side Center

- A collaborative initiative with Warren, Washington Counties Mental Health Association
- Clinic is used to provide blood pressure screenings and to answer medical questions regarding blood pressure meds. or general health information question.
- Nurses also provide supportive listening and health education to staff

AWARDS:





Health Education

Goals/Roles

- Working to promote and encourage healthy behaviors and preventing injuries by utilizing up-to-date prevention methods
- Being a resource for Warren Co. schools, employees and citizens.
- Serving as a community liaison by attending health fairs, community events and safety programs throughout the county.

2006 Achievements

Health Educators saw over 3,500 participants in their health education programs covering 15 specific topics.

Completed another successful year of “Tar Wars”, tobacco control program, with over 850 fourth and fifth grade students in Warren County in attendance.

Increased public visibility of Warren County Health Services by attending 10 community and school health fairs.

Developed new display boards to increase public awareness about Lyme Disease and West Nile Virus.



Health Education

Top 3 School Programs

Continue to be handwashing, nutrition, and tobacco control (Tar Wars) reaching over 1,700 students.

Other Responsibilities

Health Education is responsible for keeping up-to-date hand outs, pamphlets and brochure available to the public.

Health Education networks with 20 different agencies.

Health education works with the Wellness Committee to improve the health of Warren County employees through wellness programs, offering CPR classes to employees and distributing a newsletter focusing on different health topics.



2006 Public Health Program Goals

BT:

1. To increase agency visibility and become more involved in community awareness programs.
2. Continue to develop positive relationships with emergency preparedness partners.
3. To prepare medical providers, agencies and the community for pandemic influenza.
4. Assist small businesses and special needs populations to prepare for emergencies.

Rabies:

1. Continue to educate the community on the importance of vaccinating pets \geq 3 mo. against rabies.
2. Educate community on importance of not handling wildlife to minimize risk of infection w/ zoonotic diseases.



PH Program Goals Continued

Lyme Disease: Educate community on prevention measures to reduce risk of Lyme Disease infection.

Lead Program: To promote/educate providers on importance of testing all 1 & 2 yr. olds and children < 6 yrs. that are high risk for lead exposures as defined in NYS regs.

MOMS/MCH: Educate pregnant women on the benefits of natural childbirth and promote successful breastfeeding.



PH Program Goals Continued

Child Find:

1. Continue assessments of infants/family needs as they pertain to normal growth and development in the context of family environment.
2. Educate families on age specific growth and development issues including infant massage, sleep habits and behavioral concerns.

Clinic:

1. Increase awareness and utilization of new vaccines including Zostavax, Gardasil, Tdap etc.
2. Increase flu vaccinations especially in healthcare workers.

Professional Advisory Committee

Name

Patricia Auer
 Patricia Belden
 Barbara Chick, MD
 Joseph Dufour, FNP
 Dan Durkee
 Tawn Driscoll
 Gerhard Endal
 Joan Grishkot
 Ginelle Jones FNP
 Candace Kelly
 Mary Lamkins
 Daniel Larson, MD
 Richard Leach, MD
 David Mousaw, MD
 Regina Muscatello
 John Penzer
 Robert Phelps
 Sharon Schaldone
 Sara Sellig
 Carol Shippey
 Helen Stern
 Marti Tucker

Organization

Director of Health Services
 PHN, Communicable Disease Program, Health Services
 Physician Member
 Irongate Family Practice
 Health Educator, Health Services
 Financial Manager, Health Services
 Occupational Therapist
 Community Member, Retired Dir. Of Warren Co. Health Services
 Assistant Director Public Health
 Dir. Of Warren Hamilton Counties Office for the Aging
 Supervising Nurse, Health Services
 Public Health Medical Director
 Medical Consultant for Infectious Disease
 Med. Dir. for PHCP & Children w/ Special Health Care Needs Program
 Clinical Nurse Supervisor Westmount Health Facility
 Executive Director Greater ADK Home Health Aides
 Warren County Commissioner of Social Services
 Assistant Director Patient Services
 Speech Therapist
 Vice Pres. Patient Services & Chief Nursing Officer
 Immunization Program Coor., Health Services
 Physical Therapist



Business Associates Contracted in 2006

Juliet Aldrich, ST
Amy Anderson, ST
Karin Ash, PT
Laurie Aurelia, ST
Stephen Bassin, PT
Barbara Beaulac, PT
Mari Becker, OT
Heidi Bohne, ST
Diana Burns, PT
Bonita Burden, PTA
Sara Bush, ST
Judy Caimano, ST
Beth Callahan, PT
Lisbeth Caples, RD
Deborah Clynes, ST
Rebecca Compson, PT
Teresa Costin, OT
Christine Dee, ST

Theresa Dicroce, PTA
Stacie DiMezza, ST
Maggie Dochak, ST
Cathy Donohue, PT
Colleen Downing, PT
Melissa Dunbar, ST
Gary Endal, OT
Harris Foster, ST
Stacey Frasier, OT
Robert Gautreau, PT
Deborah Gecewicz, ST
Dorothy Grover, PT
Richard Gurney, PTA
Joseph Hickey, RT
Cheryl Hoffis, ST
Kelly Huntley, PT
Denise Jackson, PT
Allan Johnson, RT

Karen Kowalczyk, PT
Linda LaBlanc, ST
Mindy LaVine, ST
Jeanine Lawler, OT
Celeste Mangiardi, MSW
Suzanne Marinos, ST
Marie McGowan, ST
Kathleen O'Brien, PT
Holly O'Meara, ST
Frank Parillo, PTA
Edward Reed, PT
Donna Reynolds, OT
Geraldine Torrance, RD
Marti Tucker, PT
Heidi Underwood, ST
Sandra Watson, RD
Adam Willis, PT
Nicole Willis, PT

Public Health Emergency Preparedness Assessment Team

Name	Jurisdiction Represented	Job Title
Patricia Auer	Warren County	Director of Health Services
Patricia Belden	Warren County	PHN for Disease Control
Joseph W. Bethel	City of Glens Falls	Chief of Police
Joanne Conley	Warren County	Assistant Tourism Coordinator
Arthur Coon	National Guard	Sergeant 1 st Class/Recruiter
Rick Demers	Warr/Wash/Sar Counties	Mental Health
Mark DeSimone	Warren County	Mortician
John Farrell	Warren County	Director of Civil Defense
Anita Gabalski	NYSDOH District Office	Director – Glens Falls Office
Ginelle Jones	Warren County	Assistant Director of Public Health
Daniel Larson MD	Warren County	Medical Director
Richard Leach MD	Warren County	Medical Dir. For Infectious Disease
Marvin Lemery	Warren County	Administrator for Codes Enforcement
David Mousaw MD	Warren County	Medical Director of Pediatrics
John O'Connor DVM	Warren County	Veterinarian
Facilitator: Barbara Orton	Warren County	BT Coordinator
Hal Payne	Warren County	Adm. Westmount Health Facility
Robert Phelps	Warren County	Commissioner, Social Services
Eileen Reardon	Red Cross	Disaster Response
Shane Ross	Warren County	Undersheriff, Sheriff's Office
Sharon Schaldone	Warren County	Assistant Director of Home Care
Gary Scidmore PA-C	Warren County	EMS Coordinator
Thomas Smith	Warren County	Glens Falls Hospital Pharmacist
Laura Stebbins RN MSN	GF Hospital	Dir. of Emergency Preparedness
Helen Stern	Warren County	Immunization Coordinator
William Thomas	Warren County	Chairman, Board of Supervisors
DJ Wildermuth	NYS Police	NYS Trooper
Allison Williams	Warren County	Safety Officer, Upper Hudson Primary Care Cons.
Rob York	Warren County	Dir., Office of Community Service

HOME CARE EMERGENCY PREPAREDNESS ASSESSMENT TEAM

Name	Jurisdiction Represented	Job Title/Description
Cheryl Belcher	Warren County	RN
Michelle Benedict	Inter-Lake Health Moses Ludington	Administrator
Liz Boccia	Home Therapy Group	CEO
John Boyce	Fort Hudson Nursing Home	Director of Plant Operations
Betsy Buecking	Adirondack Manor	Director
Maureen Burger/Cynthia Mitchell	Interim Health Care	Directors
Barbara Clements	Westmount Health Facility	Administrator
Lloyd Cote	Eden Park	Administrator
Paula DeLong	Inter-Lakes Medical Supply	Director
Tawn Driscoll	Warren County	Fiscal Manager
Cathy Dufour	Warren County	PHN
Mary Beth Farmer	Upstate Home Respiratory Equip.	Secretary
Karen Fidd	Warren County	RN
Lori Fitzgerald	Albany VNA	Supervisor
Chris Freire	Glens Falls Hospital	Case Manager
Nancy Gasper	Warren County	RN
Janet Glenn	Saratoga County Public Health	ADPS
Mary Lee Godfrey	Warren County	Nursing Supervisor
Wendy Golden	Visiting Nurses Home Care	Coordinator
Donna Gorton	Hudson Headwaters Health Network	Director of Nursing
Brenda Hayes	Countryside Adult Home	Director
Tammy Heckenberg	The Glen @ Hiland Meadows	Administrator
Candy Kelly	Office for the Aging	Director
Diane Krans	Inter-Lake Health Moses Ludington	Administrator
David Lamando	The Stanton	Administrator
Mary Lamkins	Warren County	Nursing Supervisor
Kathy Liddell	North Country Home Services	Office Manager
Barbara Lyons	Anthem Health Services	Vice President
Angela Meade	Warren County	PH Liaison